State of California

LITTLE HOOVER COMMISSION

October 17, 2001

The Honorable Gray Davis
Governor of California

The Honorable John Burton
President pro Tempore of the Senate
and members of the Senate

The Honorable James L. Brulte
Senate Minority Leader

The Honorable Robert M. Hertzberg
Speaker of the Assembly
and members of the Assembly

The Honorable Dave Cox
Assembly Minority Leader

Dear Governor and Members of the Legislature:

Last year the Commission issued a report on mental health services for California's adults. In that review we discovered that California explicitly rations care to only those with the most extreme needs – and even then we turn people away. The Commission called for California to ensure that everyone who needs care receives care.

In this report we turn our attention to children. And while services for children are better financed, there is still no overarching commitment to ensure that essential services are provided.

As a result, children also endure a system that turns them away until their needs are severe. Because there are no standards, children often do not receive the right care at the right time in the right way. Because we do not measure outcomes, there is no pressure on the system to improve.

The costs and consequences of these results are unacceptably high, but are not well-known. Jailers concede that boys and girls are locked behind bars because we have chosen not to provide necessary treatment services. Research shows that just one in four children who are burdened by emotional and behavioral needs graduates with a diploma. Many are shunted into independent learning programs where they struggle without needed support. And about half of the children in foster care do not receive the treatment they need.

Most appalling, despite ample opportunities to provide appropriate care, little children – some who enter foster care as babies – can be repeatedly traumatized by their families, by other children, and by a system that fails to meet their needs. Some are institutionalized for the rest of their lives.

These tragedies are repeated daily for children who are cast into a maelstrom of rules and regulations that are not based on their best interests. A few of their stories are told in this report. Most of these children have extreme needs that in some cases are the product of the system itself. The untold stories are of those children who are never helped at all.

Moreover, these circumstances are not limited to a few thousand children in the most dire straits. Inadequate mental health care undermines higher profile public efforts. Children can't learn when they are threatened or distraught because of discord in their home or when they are fearful of the violence in their neighborhood. Alternatively, appropriate care can help children learn and make better choices, often crucial decisions that can lead to either a life of incarceration or a life of contributions.

We demand that our computers get faster, cheaper and easier to use. We return to businesses that provide quality service. We strive for universal medical coverage and work hard to improve our public schools. But we are content with a mental health system that fails more children than it serves.

The Commission applauds and respects the thousands of individuals who go to work each day to help children who are struggling to survive. Their battle is not with unruly children. Their battle is with the constricting rules that constrain their ability to make the best use of existing resources.

During good times, these professionals labor to create another program. During tough times – like those on the horizon – they struggle to salvage a program or two. While exhaustive to fight, these battles are on the margin. The outcome is a few more services to a few more children. Rarely do these efforts bring significant relief to significant numbers.

Like California's famed mystery house, the State has a delivery system that was built but never planned. New programs are layered on top of old services. Children who enter the system through the wrong doorway find staircases leading nowhere. Others end up behind locked doors, forever prevented from getting the services they need.

Over the last decade the Commission has reviewed children's services from a variety of perspectives and has confronted similar maladies. We forego opportunities to prevent harm. We fail to integrate services. We measure little and demand even less. California must redesign this billion-dollar system. Recommendation 5 in this report outlines a strategy to address these challenges.

The task is difficult, but it will only get harder and more costly if we wait. We need the leadership to set clear goals for children and families. We need the courage to challenge how we are spending the billions that are allocated to children's services. And we must have the persistence to examine every program and redesign a single system around children in the context of their families.

It is painfully clear that California must bring new resources to support prevention programs, to help more children succeed in school and to give each child the chance to thrive not just survive. Through mental health coverage and other contributions, the private sector must join the public sector to ensure that all children in California have access to quality care. But money alone is not sufficient. California must establish clear expectations for success. The public must understand the costs and consequences of failure. And the public and policy-makers must create constant pressure for improvement.

Sincerely,

Michael E. Alpert
Chairman

Young Hearts & Minds

Making a Commitment to Children's Mental Health

October 2001

The Artwork in this Report

Children experience mental health needs in diverse ways and circumstances. The masks depicted on the cover were produced by children dealing with the loss of a loved one as part of the Children's Bereavement Art Group in Sacramento. The poem "Face Me" was written by 14-year-old Kristin for the Arts in Mental Health Program at Metropolitan State Hospital. These verbal and non-verbal messages reveal the anguish experienced by many children and can help shape our commitment to provide high-quality care.

Face Me

Don't turn around,
Face Me.
Don't walk away,
Face Me.
Don't close the door,
Face Me.
Don't shut me out,
Face Me.
Don't leave me lonely,
Face Me.
Don't close the window,
Face Me.
Please, whatever you do don't leave me,
Face Me.

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Executive Summary

Every neighborhood has a family in crisis. Economic and social stresses threaten their stability. Alcoholism and domestic violence shatter their bonds. More and more children are growing up angry, homeless – even hopeless.

For all of the wealth, innovation and productivity of 21st century California, many communities are still besieged by despair, destructive behavior and silent suffering. In many cases, mental health issues are a cause or a consequence of these public maladies.

More than 1 million children in California will experience an emotional or behavioral disorder this year, and more than 600,000 will not receive adequate treatment. For some of these children, their symptoms will go unnoticed; their needs will not be understood. For others, the symptoms will be obvious to parents, teachers and doctors, but they will not receive attention because of how California organizes, funds and delivers mental health care and other services.

With prevention and early intervention, many mental health problems could be avoided, reduced or resolved. Alternatively, inadequate care leads to a worsening of symptoms, with costlier consequences requiring more expensive responses.

More than Mental Health

Since 1994, the Commission has issued six reports on state policies for children, including: studies on juvenile justice, boot camps, child support, child care, abused and neglected children, and youth crime and violence prevention.

Based on those studies and this review, it is clear that mental health reform alone will not significantly improve services for troubled children and their families.

Rather, more holistic reforms are needed to integrate services to these Californians. In Recommendation 5 of this report, the Commission outlines a strategy to better align services for children with their needs. With the right reform, California can serve more children with less money and with more successful outcomes.

Children can access public mental health through three doors: programs for low-income families; programs for children in foster care; and, in some counties, programs for children receiving other services, such as those in the juvenile justice system or in schools.

But getting through the door does not always mean getting help. More than 50,000 children in the foster care system who may need mental health services do not get them.[1] Some 50 to 90 percent of the children in the juvenile justice system need care – many of them also victims of early abuse and neglect – and many of them do not receive services.

Some of these children are incarcerated simply because their county does not offer appropriate mental health treatment.[2]

Then there are the children who never get through the door – children from families that are not eligible for publicly funded services. Still, they suffer emotional, physical and psychological problems that diminish their future, their families, their classrooms and their communities.

In Los Angeles County alone, an estimated 100,000 children need help, but face barriers to care and so are adrift in a world of increasing challenge.

Defining Childhood Mental Health Needs and Responses

This report explores the needs of children from birth to their early adult years. Yet the mental health and related needs of a 2-year-old are different from those of a 12-year-old or a 22-year-old. And while researchers and practitioners are rapidly discovering how children experience mental health needs, this work is not complete.

The U.S. Surgeon General reports there is "no clear line between mental health and mental illness" in adults. Defining mental health and mental illness in children is far more complicated. The complexity is linked to the rapid social, emotional and intellectual development of children. In general, like mental illness in adults, mental illness in children is linked to not meeting expected developmental milestones. Significant variation from expected norms in development can be understood as representing a mental illness. The terms "emotional disorder" and "behavioral disorder" also are commonly used to represent childhood mental health needs.

However, some argue that because children experience such rapid and dramatic developmental changes, atypical development is best understood as delayed development or maladjustment. To them, the terms "mental illness" or "disorder" are inappropriate because children continue to develop and atypical development can be addressed with education and support. Further, atypical development can be in response to an environment that disrupts their ability to reach expected milestones. In those instances, children are developing according to the cues offered by their environments. They are not ill, but the environments in which they are living may be.

Throughout this report the Commission has attempted to capture the best available knowledge on childhood mental health. The terms "mental health," "mental illness" and "disorder" are used in this report because they reflect the most accepted and understood terms. However, the Commission recognizes that mental health needs are linked to a child's development and a developmental perspective might best guide mental health policy.

This ongoing dialogue on the best way to understand and describe mental health needs in children influences the notion of "curing" a mental disorder or promoting recovery. With the appropriate response and support, children can almost always overcome the hurdles that disrupt their development or result in mental health needs, particularly young children. For older children, these challenges are more difficult to address and some do experience mental illnesses, such as schizophrenia, as young adults. For the majority, however, prevention, early intervention and appropriate treatment can help them meet their developmental milestones and grow up healthy.

The value of prevention is magnified when it is recognized that like adults, children whose needs are not met turn to drug use or other destructive responses to stress, anxiety or fear. Frequent drug use can compound their needs or they can end up in the juvenile justice system. Other children end up in trouble because of aggressive, defiant behavior. Unaddressed mental health needs and their consequences can create a downward spiral of more severe symptoms, needs and concerns that are expensive to address and defy simple solutions.

California's goal should be to ensure that all children who need mental health services receive the care and support necessary to mature into healthy, productive, independent adults. These services should seize three opportunities:

1. ***To prevent greater needs.*** Every effort should be pursued to provide appropriate mental health care to children before their needs disrupt their learning, their healthy development, or escalate into costly and more complex issues.
2. ***To intervene early.*** No child should be incarcerated, refused entry into school or denied high-quality educational services because of an unaddressed mental health or related need.
3. ***To treat when necessary.*** All children with identified mental health needs – regardless of legal or economic status – should have access to appropriate publicly or privately funded mental health and other services that support their rehabilitation, adjustment and educational success.

There is broad agreement that children should have access to a quality education, grow up safe, healthy and with a clear chance to lead successful, productive lives. But the importance of mental health care in achieving those goals has not been fully recognized.

As a result, we have suffered the consequences: lower educational outcomes, lower productivity, diminished health, increased violence, and for virtually everyone, less peace of mind.

Recognizing and Responding to Stigma

The U.S. Surgeon General recognizes stigma as one of the greatest challenges to mental health policy:

> *Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia. It reduces patients' access to resources and opportunities (e.g. housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its more overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society.*

The U.S. Surgeon General has identified several strategies to improve understanding of mental health needs and the efficacy of responses. He suggests increasing awareness through:

- Advocacy
- Public Education
- Increased contact with people who have experienced mental health needs.
- Improved research on causes and effective responses.

In its November 2000 report the Commission recommended a statewide campaign to help all Californians understand the nature and consequences of mental illness – and prevention and treatment opportunities.

Seeing the Whole Child

Over the last 10 years, experts have documented the complex needs of troubled children, and the importance of sophisticated solutions. Yet with each new study – as with each new Columbine – we put a new program, a new remedy, into the corpus of public programs that we so desperately hope will heal our children, our families and our communities.

Despite the integrity of individual programs – and even with the extraordinary contributions of so many individual professionals – incremental efforts add up to less than the sum of their parts. The programs often fall short of providing the right services, in the right way, to the right children at the right time. Year after year, new commitments – even with additional funding – fail to achieve the goals so desperately desired.

But from the perspective of a troubled child, the quality of care is severely limited by an additional problem: the bewildering and expensive patchwork of social, health, educational and other services that fail to meet the sophisticated needs of young and developing human beings in the context of their families.

In its November 2000 report examining the public mental health system for adults, the Commission was struck that California strictly rations services to only those adults in the greatest need of help.

But from the perspective of a troubled child, the quality of care is severely limited by an additional problem: the bewildering and expensive patchwork of social, health, educational and other services that fail to meet the sophisticated needs of young and developing human beings in the context of their families.

The barriers to high-quality mental health care are the same as those for other services needed by children in foster care, or on probation, or struggling with life below the radar:

- Funding is restricted by complex rules that encourage communities to forsake those in the path of danger and focus only on those children who are physically bruised and emotionally broken.

- Service providers are required to see boys and girls as something other than children. The public's response is distorted by the legal labels of victims or perpetrators, even though we know the trauma of the first often results in the second.

- And no one individual or agency is responsible for ensuring that a child who needs five helping hands to keep from going over a cliff, does not receive just four. Rather, programs respond – and their responsibility is narrowly limited to – where children sleep, or where they learn, or how they feel, or whether they cry versus whether they hit. No one's job is to make sure they are safe and healthy, learning and at home, and out of trouble.

California will spend over $56 billion for an array of child and family services in the next year.[3] Clearly, if the State were to design such an enormous system today, it would look different than this crazy quilt of entitlement, categorical and pilot programs. No services are holistic. No one is accountable for how decisions affect the overall quality of life of children or their families. Divergent eligibility criteria often mean that parents and children, even individual siblings, receive different services from different providers. Disparate programs translate into little or no continuity of care as children age or their needs evolve.

Reforming the way California provides services to children and families will be difficult, but will never get any easier. Each year a new layer of pilot programs and other piece-meal reforms are added, making wholesale change all the harder.

Reforming service delivery systems will take time, but the effort is warranted. The present system is failing sufficient numbers of children and families, and the investment in these programs is too large not to demand greater efficiencies and accountability.

But most important, reforming these systems is essential if to provide adequate services to everyone in need. There may be enough resources if done right. There will not be enough resources if we continue to do this wrong.

The Commission and others have previously recommended many of the solutions outlined in this report. But the problems have gone unaddressed – and continue to erode the quality of life of children, their families and California's communities.

The Costs of Failure are High

Mental health and related services can provide children the support they need to stay in school, avoid criminal behavior and remain in their homes. Unaddressed mental health needs result in increased school failure, juvenile justice costs, and residential treatment and state hospital costs.

- Local juvenile detention facilities spend about $3,500 to house a child for the average 27-day stay. The average daily census for local detention facilities was 11,529 children.
- The California Youth Authority spends $3,100 per month to house a child. It spends an additional $1,750 to offer treatment. Some 7,200 youth are served each month.
- One month in the state hospital costs $10,000. There are over 200 children in the state hospital each month.

Many of the challenges facing troubled children and their families today are the unintended consequences of short-term fixes and narrow vision

of the past. Each recommendation includes a strategy to address a fundamental challenge and the practical first steps that can make that reform successful.

After careful analysis, and after consulting extensively with many dedicated and knowledgeable Californians, the Commission submits the following recommendations for consideration.

Ensure Appropriate Care

Finding 1: Too many children suffer through mental health needs without the benefit of appropriate, compassionate and holistic care.

In the last decade new resources for children's mental health have encouraged local agencies to pursue innovative strategies for addressing the broader needs of children. These efforts recognize that high-quality mental health care can support a child's learning, prevent criminal behavior and promote positive physical and emotional development.

Still, thousands of families do not receive care and others receive inadequate care. Many families do not recognize that the right services could improve children's learning, prevent their incarceration, and support their success.

The challenge that families, community leaders and policy-makers face is understanding the services that are available, the services that are needed, and where improvement should be focused. Five fundamental problems underlie the mental health system:

No commitment to meeting needs. California has not established a policy vision – such as all who need care will receive services – that can guide policies and programs and outline strategies for success.

No inventory of needs. Counties have not explicitly assessed their needs. Local leaders and mental health officials are unclear on who lives in their communities and the types of risks that children and families face and how those risks

Building a Continuum that Reflects Healthy Child Development

Needs assessments and standards must reflect the range of issues affecting children throughout their lives. Appropriate health and mental health care for mothers can insure their babies develop into healthy children and then into healthy adults. Care for very young children can prevent the need for services as they age and become adults. Among the opportunities:

Birth to age 5. Young children present the greatest opportunity to respond early to risks and prevent the need for mental health services.

Ages 5 to 18. All children facing school difficulties or who are in foster care or the juvenile justice system should have access to appropriate mental health care.

Ages 18 to 25. Mental health needs do not stop when a child turns 18. This transition age is often the most stressful period in a person's life as new responsibilities are assumed and new challenges must be addressed. Counties should ensure that appropriate mental health care is available until a person is able to function on their own, transition into a robust adult mental health system or at least until age 25.

make them vulnerable to needing services.

No definitive standards. California has not established definitive standards or expectations that provide clear direction on how best to identify children at risk of needing services and how best to serve them.

No pressure for reform. In the absence of clear standards and expectations, parents and policy-makers are unsure if existing funding and programs are adequate. And where parents and other advocates are active, they are unsuccessful in their attempts to motivate policy-makers to improve the service delivery system.

No focus on prevention. Without a clear assessment of risks, needs and standards, counties have been unable to focus on preventing the need for expensive downstream services. Prevention offers the greatest opportunity to serve the most needs in the most cost-effective manner.

An immediate step toward ensuring that every child in need receives high-quality services is to make better use of existing resources to reach more children with higher quality care. More fundamental reform will require political and community support. It will require local officials to identify gaps in their service system, to document the costs of failure and to demonstrate need. Reform will require pressure from families and communities for local officials to align services with needs. It also will require advocacy and accountability at the state level to understand the statewide costs and consequences of inadequate mental health services and how state policies and funding rules inhibit improved outcomes.

Children, Learning and Mental Health

California makes an enormous investment in children. Public programs are designed to help them learn, develop problem-solving skills and rouse a curiosity for the world around them. A child's learning process starts with the family, involves child care providers and schools. Mental health providers are essential partners in this investment. Children struggling with depression, anxiety, or those who have not developed the skills to appropriately interact with peers or teachers cannot learn to their optimal ability.

Increasingly K-12 and early childhood teachers are seeking the support and guidance they need to aid struggling children. They recognize that community mental health providers can help them ensure that no child fail to learn or develop healthy social and problem-solving skills because of unaddressed mental health needs. Yet school-mental health partnerships do not happen without initiative. In Los Angeles and Vallejo, and many other communities across California, school- and childcare- based programs are helping children overcome mental health needs so that they can be better learners, family members and neighbors.

The lesson of these partnerships is that new categorical funding for school-based or child care-based mental health services would be the wrong approach. A categorical program would inevitably ration care in a few schools. A more robust solution would promote local partnerships that tap all available resources to meet local needs for as many children as possible.

Recommendation 1: The Governor and the Legislature should establish a commitment that all children with mental health needs shall be eligible for and receive high-quality, efficient mental health and related services. Legislation should:

- ***Require each county to establish a Child and Family Services Board***. The role of the board could be assumed by an existing entity. The board in each county should:
  - ✓ ***Assess needs***. Each county should understand how many children are at risk for needing services, how many require care and what types of services they need.
  - ✓ ***Document available services.*** Each county should clearly document the availability of mental health and related services in its communities.
  - ✓ ***Define gaps in needed care***. Each county should compare needs with services to determine deficiencies in the availability of services in its communities.
  - ✓ ***Develop a strategy to address those gaps.*** Each county should develop a strategy to address unmet needs.
  - ✓ ***Develop mechanisms to locally report on needs, gaps and progress toward meeting those needs.*** Each county should clearly and periodically report on local needs, gaps in the continuum of care and current efforts to address those gaps.

- ***Establish an Office of Prevention within the Department of Mental Health***. The Office of Prevention should be charged with identifying prevention opportunities and advocating for prevention, including documenting the costs and benefits of prevention strategies in mental health and related fields.

- ***Plan for private-public universal coverage.*** The Department of Mental Health, with support from the Legislative Analyst's Office and the Department of Finance should:
  - ✓ ***Identify coverage goals.*** The department should determine what percentage of the population should have private sector mental health insurance coverage and what percentage should be served through public sector programs.
  - ✓ ***Calculate the cost.*** The department should document the costs of providing public sector coverage to the target population.
  - ✓ ***Develop a strategy***. The department should outline the steps to offering 100 percent needed services to the target population and participate in the task force on private sector mental health coverage outlined in Recommendation 2.

- ***Establish a Human Service Research Center.*** The center should be a partnership between the California Department of Mental Health, local mental health agencies, public and private universities and others. It should be charged with the following tasks:
  - ✓ ***Develop clear standards to guide policy.*** The center should establish clear standards that will guide expectations for the delivery of mental health and related services. Standards should be formulated that indicate the goals to be realized with public programs.
  - ✓ ***Develop an information clearinghouse.*** The center should document and disseminate information on the latest available knowledge on proven, promising and disproven service delivery approaches, treatment protocols and other issues relevant to the human service delivery system.
  - ✓ ***Identify incentives.*** The center should encourage the adoption of proven and promising approaches to service delivery. It should develop strategies that encourage local agencies and professionals to continuously upgrade skills, treatment approaches and other practices that will improve outcomes for children and families.
  - ✓ ***Serve as a research and data pipeline.*** The center should serve as a single point of access to state data. It should develop streamlined policies for human subject reviews and other necessary research protocols. It should develop research agendas relevant to policy-making and the delivery of services, and support grant writing and other efforts that improve awareness, dissemination and adoption of proven and promising practices. The center should guide and advise state efforts to evaluate social service programs.
  - ✓ ***Provide public access to performance data.*** The center should develop a publicly accessible information source, such as a Web site, that presents county and statewide data on policy goals, benchmarks, service availability, funding and outcomes.

Building a Foundation for Reform: First Steps

- ✓ The Department of Mental Health, in conjunction with other state departments, should determine what percentage of the population should be expected to receive mental health care from the public sector.
- ✓ Counties should form or designate a child and family board to determine broad community needs, assess gaps in services and outline a strategy for addressing them.
- ✓ The Department of Mental Health should develop a budget change proposal to create an Office of Prevention.
- ✓ The Legislature should direct the Department of Mental Health to solicit proposals for the development of a Human Services Research Center.

Provide Appropriate Resources

Finding 2: Mental health funding fails to promote quality, efficient care.

California has not adequately leveraged the ability of the private sector to provide mental health coverage. As a result, public funding is spread thin trying to meet multiple demands. Programs serving children and adults compete with each other for limited funding that is inadequate to address the full range of needs or the number of people needing care.

The challenge of funding reform is compounded because available resources are not well organized. Specifically:

Mental health funding is ineffective. Many children fail to receive the care they need to recover because of limits on services – including limits on who can be served and when they can be served.

Mental health funding is inefficient. Treatment services are available, but prevention services are not. Short-term treatment goals are given a higher priority than services to address long-term outcomes. And funding rules do not create incentives that encourage counties to provide children the most cost-effective treatment.

Mental health funding creates inequities. Grant and pilot programs allow some counties to provide more comprehensive services to more children, while other counties place more limits on who receives care and the services they receive. Additionally, funding rules force providers to deliver services based on diagnosis, regardless of needs. The result is some children can receive comprehensive care, while others with similar diagnoses receive only limited care, and still others are ignored until their needs escalate.

Mental health funding should motivate good outcomes. It should encourage counties to pursue the most effective, efficient strategies for providing care. It should create incentives for investing in proven and promising practices, reducing the use of unproven approaches, and documenting results. Funding should prioritize prevention and address the needs of children regardless of their diagnoses. The Commission has recommended that California reform mental health funding in the following way:

- ***Create a Stable Funding Base.*** The majority of mental health resources should be stable, provide incentives that promote efficiency and effectiveness, and give local agencies discretion to tailor programs to meet individual needs.

- ***Provide Incentives to Do Better.*** The State should provide financial incentives to motivate local authorities to adopt practices proven to enhance services.

- ***Make Room for Innovation.*** A third tier of funding should promote innovation, and encourage counties to invest in approaches that hold the promise of increasing the efficiency and effectiveness of mental health programs.

California also should expand private sector mental health insurance coverage. Mental health insurance parity is a start. The majority of Californians should receive mental health care through private insurance, allowing the public sector to concentrate on building an appropriate safety net for people without coverage.

These recommendations restate the Commission's concerns for mental health funding as outlined in its November 2000 report, *Being There: Making a Commitment to Mental Health.*

Recommendation 2: California should ensure that public or private funding is available to provide efficient, effective mental health care to all Californians.

Immediate reform should:

- ***Assess available resources.*** The Department of Mental Health should provide a comprehensive analysis of why counties are not making full use of available resources.

- ***Document costs.*** The Department of Mental Health should identify the State's share of additional costs to provide adequate services to all who need care and the consequences of not serving these children.

- ***Explore access to federal funding.*** The Department of Mental Health should explore the use of federal waivers to 1) tap into additional resources and 2) make better use of existing resources. Specifically, the department should pursue a waiver to use Medi-Cal to fund mental health services in the juvenile justice system.

- ***Form a Mental Health Insurance Task Force.*** The task force should be charged with expanding private sector insurance coverage for mental health care. It should identify the criteria for a robust private sector mental health insurance market and outline how the State could support that market. The task force should include representatives of the insurance industry, mental health stakeholders and state departments.

Long-term reform should:

- ***Revise the structure of mental health funding.*** The California Department of Mental Health should develop a plan to sunset, over time, existing categorical and grant programs and fold that funding into three sources that have the following characteristics:
  - ✓ ***Stable base funding that motivates quality outcomes.*** The lion's share of mental health funding should include incentives for local mental health agencies to continuously improve services.
  - ✓ ***Incentive funding for the adoption of best practices.*** A second funding stream should be used to encourage local agencies to adopt proven programs.
  - ✓ ***Innovation funding to encourage experimentation and risk taking.*** A third source of funding should promote innovation and risk taking to encourage local agencies to explore new, more effective approaches to providing services.

Building a Foundation for Reform: First Steps

- ✓ The Department of Mental Health should issue a report that lists all available resources that can be used to provide mental health services.
- ✓ State associations representing local agencies should form a task force charged with developing best practices and technical assistance to ensure each county fully accesses available funding for mental health services.
- ✓ Individual counties, school districts and other local agencies should review their use of funding to support mental health services.
- ✓ The Department of Mental Health should identify counties that are not accessing all available funding for mental health and dedicate existing staff to help those counties access those funds.
- ✓ The Legislature should form a task force to determine the elements needed to provide private sector insurance coverage for mental health care for the majority of Californians.
- ✓ Local agencies should formally request that the Health and Human Services agency champion a federal waiver to use Medi-Cal funding to ensure that all children in juvenile justice programs receive mental health services. The Health and Human Services Agency should request that waiver.
- ✓ The Health and Human Services Agency should identify barriers to accessing additional federal dollars to serve children and families with mental health needs.
- ✓ The Department of Mental Health should draft a plan to collapse existing categorical funding into a three-tiered funding source for mental health services.

Invest in Leadership

Finding 3: Successful and sustained improvements in children's mental health care require an ongoing commitment to developing talented and dynamic leaders.

The fundamental challenge in mental health care is one of leadership. Nearly all mental health needs can be addressed with existing knowledge in medicine, treatment and support services. And that knowledge is getting better each year. To improve mental health care, California must ensure that existing and new knowledge and resources are applied in an efficient and effective manner. Doing so requires leadership.

Talented leaders translate knowledge into cost-effective, timely services. And they aggressively pursue new approaches to providing efficient, effective services. Too many promising and proven approaches to helping children and families have failed because local administrators did not receive the direction and support needed to be successful.

State and local mental health leaders face enormous challenges to developing highly efficient, effective continuums of care. They must be able to:

- ***Articulate a vision***. County mental health directors need to be able to establish a clear organizational vision for public programs and build the internal and external support necessary to realize and sustain that vision.
- ***Build partnerships***. County mental health programs need to work closely with schools, social services, juvenile and criminal justice programs and other agencies. Local mental health directors must build partnerships with other public, private and non-profit agencies to best address shared goals for children and their families.
- ***Manage people***. County mental health directors must be able to rely on the support and expertise of clinical, fiscal and administrative staff in the operation of county programs. Building the necessary trust and confidence requires directors to understand and respond to the needs of staff and empower them to contribute to the best of their ability.

State Leadership Challenges

In its report on the adult mental health system, the Commission identified a number of challenges that require leadership to resolve. Among them:

- Providing adequate funding and promoting efficient spending.
- Addressing human resource needs.
- Focusing on prevention and reducing stigma.
- Developing, documenting and disseminating best practices.
- Meeting the need for comprehensive community services.
- Managing a growing penal code client population.
- Addressing demands for reform of involuntary commitment laws.
- Implementing managed care.
- Supporting mental health parity.
- Improving oversight and accountability mechanisms.

- ***Demonstrate political leadership***. County mental health directors must be able to assess the interest of elected officials, build public awareness and support for mental health care, expend political capital when necessary, work with the media and community, and represent the county as the mental health authority.

Few mental health leaders have formal training in organizational management, directing organizational change or leading complex service delivery systems. All would benefit from formal education in these areas and from a network of skilled leaders familiar with these challenges.

The structural answer to improving leadership in mental health care is to create incentives for counties to do the right thing at the right time and to streamline regulations that make it hard to do the right thing. Incentives will encourage all counties to directly invest in leadership. In the meantime, with or without structural reform, improving services will require leadership expertise.

Losing Institutional Knowledge

The California Mental Health Directors Association has identified leadership as a fundamental challenge facing California's mental health system.

In the last five years, 24 percent of local mental health directors have retired. In July 2001, 12 percent of all director positions were vacant. And another 25 percent of directors are expected to retire within the next five years.

Source: California Institute for Mental Health.

State policy-makers should recognize that to achieve the results they want from mental health programs they must support the ability of counties to be successful.

The challenge is to increase the number of counties aggressively implementing proven and promising practices, identifying the barriers to improved efficiency and effectiveness, and building leaders skilled at advocating for the relief and support necessary to serve all families in need of care.

Recommendation 3: The Governor and the Legislature should invest in a leadership initiative that will provide existing and emerging leaders with the skills they need to be successful. The initiative should:

- ***Involve the right partners.*** The initiative should involve the California Department of Mental Health, the California Mental Health Directors Association, the California Department of Personnel Administration, clients and family-members, university-based experts and others to fully address the needs of current, emerging and potential mental health leaders.
- ***Cover the essential topics.*** The initiative should provide intensive, and continuing education on the topics essential to building and managing a high-quality mental health system, including:

articulating a vision, building partnerships, managing people, accessing funding, communicating goals and measuring progress.

- ***Utilize a range of strategies***. The initiative should include a range of strategies to address the needs of diverse leaders. It could provide classroom education on the latest in conflict management, personnel laws, management approaches and other on-going issues. It could provide workshops around the state on topics of particular concern, such as cultural competency, blending funding and team building. And it could convene high profile conferences to identify, explore and educate on emerging issues impacting statewide goals, such as the need for residential care, providing mental health care through the juvenile justice system and ensuring that all children with mental health needs receive adequate educational services.
- ***Offer incentives to participation***. The initiative should explore the value of a certificate program or other strategies that will encourage public and private mental health providers to determine the most cost-effective way to involve potential, emerging and existing mental health leaders in the activities of the initiative.
- ***Build capacity for continuous improvement.*** The initiative should bring together existing leaders to develop and implement special projects that offer the potential for statewide benefit and demonstrate the value of continuous improvement. The initiative could explore the potential of universal healthcare – such as the program underway in Santa Clara County - the employment of mental health clients as para-professionals, or the role of the state mental hospital in providing a continuum of services.

Building a Foundation for Reform: First Steps

- ✓ The Legislature should enact legislation to create and fund a leadership initiative under the direction of the Health and Human Services Agency.
- ✓ The Health and Human Services Agency should form a working group with statewide association representatives, researchers and other partners to outline the goals and strategies for a leadership initiative across the human services.
- ✓ The California Mental Health Directors Association should outline the skills of an effective mental health director and issue recommended training and skill standards for new local agency directors. The Association should identify training opportunities for local directors and identify funding sources to encourage existing and emerging directors to participate in formal training programs.
- ✓ Local mental health directors should solicit funding from their Boards of Supervisors to pay for their training needs.
- ✓ Local mental health organizations should advocate with local Boards of Supervisors to require and fund leadership training for local mental health directors.

Ensure Sufficient Personnel

Finding 4: Children and families are denied access to adequate and appropriate care because California has not appropriately addressed the acute shortage of qualified mental health professionals.

People make California's health care system effective. Without professional service providers there is no health care, no cures, no recovery for children or adults. California cannot expand high-quality mental health care, enhance prevention, and improve the efficiency of care without sufficient mental health personnel.

California's Human Resource Crisis

According to the California Mental Health Planning Council, the vacancy rates for mental health professional positions statewide exceeds 30 percent.

- In the Bay Area it takes four months to fill licensed clinical social worker positions.
- In the Central Valley, it can take 10 months to fill similar positions.
- Los Angeles County has a 30 percent vacancy rate for psychiatrists.
- In the northern region, it can take almost a year and a half to fill vacancies for psychiatrists and psychologists.

In its November 2000 report on mental health, the Commission argued that addressing the human resource challenge should be a fundamental concern of the California Department of Mental Health. This recommendation outlines a strategy for addressing this challenge.

Marvin Southard, the director of the Los Angeles County Department of Mental Health, testified that more than money, his county needs the mental health staff to serve the children and families of Los Angeles. Because of staff shortages children suffer through excruciatingly long waiting periods to see doctors, social workers or case managers. Sometimes care is delayed. Other times people end up in hospitals, jails or on the streets because no one was available to care for them.

There are many potential barriers to addressing this issue. Certainly there are too few applicants to work in the mental health field. But why more people are not applying for these positions has not been determined. The California Mental Health Planning Council attributes bureaucratic barriers within county personnel systems as a contributing factor. The Assembly Human Services Committee has heard that a poor image discourages people from entering human service fields. The multiple efforts to understand this issue have identified the following problems:

- ✓ Inadequate supply of trained staff.
- ✓ Complex hiring rules cause undue delay.
- ✓ Poor public image of the field turns away potential applicants.
- ✓ Stressful workloads discourage new entrants and increase turnover.
- ✓ Poor alignment of training with the realities of the workforce limit retention.
- ✓ Limited support for staff and professional development encourages turnover.
- ✓ Low pay and benefits reduce the attractiveness of the profession and retention.

Unfortunately, there is no comprehensive analysis of these barriers, how they interact, or where attention should be concentrated. Potential solutions include:

Recruitment. California could investigate the extent that improved recruitment, including a coordinated national recruitment campaign, could attract more applicants to the field.

Training Academies. Some counties have found success with training academies that allow an individual to study while gaining on-the-job experience with a mental health agency.

Scholarships/Loan Forgiveness Programs. The Office of Statewide Health Planning and Development provides financial assistance to students entering the health professions. Additional investment in this strategy should assess the effectiveness of existing efforts and ways to improve the efficiency and effectiveness of these programs.

Workload Analysis. A workforce analysis could assess the extent that vacancies are caused by people moving out of the mental health field rather than simply a limited supply of qualified workers.

Core Competencies. Workforce development efforts could assess the alignment of training programs and the needs of the field. California has the infrastructure to address this issue, but its public agencies are not working together to do so. Among the agencies that should be enlisted:

- The Employment Development Department offers the technical knowledge to forecast needs and assess trends in mental health employment.
- The Office of Statewide Health Planning and Development has the experience and responsibility to move people into health fields.
- The Employment Development Panel and the community colleges have the capacity to link employers with training and education providers.
- The Regional Collaborative model, which brings together education, workforce preparation, and economic development interests in five regions of the state, could be expanded to address human service workforce needs throughout the state.[4]

But these efforts will not be successful if pursued independently. Workforce development efforts should be coordinated and continuous. They should capitalize on the forecasting and data analysis skills of the EDD and identify emerging needs before they reach crisis proportions.

California has all the elements needed to ensure adequate numbers of trained professionals for the mental health and human service fields. The right leadership, the right goals and accountability for outcomes could bring those elements together to address this critical need.

Recommendation 4: The Governor and the Legislature should direct the Health and Human Services Agency to address this crisis. Specifically, the legislation should:

- ***Call for a human service workforce summit.*** The Health and Human Services Agency should convene a human service workforce summit to better understand and address the personnel needs of public and private sector human service employers and personnel. The summit should bring together public and private agencies and organizations working to address this issue. The summit should:
  - ✓ ***Document needs.*** The summit should bring together researchers and others to clarify the present and future human service workforce needs in California.
  - ✓ ***Document barriers to entering the workforce***. The summit should identify and clarify the barriers that make it difficult for people to enter the human service workforce. Barriers to be considered should include inadequate supply of trained personnel, compensation, workload, work environment and any other factors considered to impede the recruitment and retention of qualified human service employees for public sector and private sector employment.
  - ✓ ***Identify strategies to respond***. The summit should identify the present capacity of California to respond to these barriers. It should document where present capacities are inadequate. And it should identify strategies for improving the ability of public and private training institutions, public and private employers, guilds, unions and others to work together to improve the capacity of California to respond.
  - ✓ ***Review the appropriateness of expanding the use of para-professionals in mental health and related fields.*** Expanding the use of practice models that rely on mental health clients, peer support groups, and other para-professionals to address mental health and related needs could improve access to care and address staffing needs.

- ***Assess overlap, duplication and gaps of mission, authority and funding of workforce development programs.*** The Health and Human Services Agency should form a task force to review the allocation and organization of existing workforce development resources and make recommendations to reduce duplication and conflict. The task force should:

  - ✓ ***Identify unmet needs.*** The task force should assess whether California has adequately invested in workforce development and can respond comprehensively to workforce needs. It should include recommendations for improvements.

  - ✓ ***Document the ability and incentives of workforce development programs to work together to forecast needs and formulate responses.*** Public entities should work together to address needs and strive to continuously improve California's response to workforce development needs.

  - ✓ ***Review the appropriateness of existing data, data analysis and forecasting models.*** The task force should review whether the Employment Development Department and its programs are presently able to accurately reflect and respond to the realities of a changing workforce and workforce needs and how those programs can be improved to guide the efforts of policy-makers interested in improving workforce development.

Building a Foundation for Reform: First Steps

- ✓ The Legislature should direct the Health and Human Services Agency to convene a human services workforce summit.
- ✓ Statewide and local mental health organizations should collectively ask the Health and Human Services Agency to detail the efforts underway to address present workforce needs and align ongoing research and intervention programs to ensure adequate and culturally competent personnel are available as the need for mental health services evolves.
- ✓ Local mental health departments should develop partnerships with community colleges, CSU and UC campuses to align training programs with the demands of employment. Where necessary, local Boards of Supervisors should be encouraged to ensure that community college leaders prioritize public sector workforce needs when determining how to best use limited community college resources.

Remember the Child

Through numerous public policy reviews the Commission has looked at how California provides services to children and families. The Commission has examined the child welfare and juvenile justice systems. It has looked at education, youth crime and violence and child care and child support policies. And in this report and a November 2000 report it has looked at mental health policy.

In each of these studies the Commission unearthed a core set of concerns that prevent many children and their families from accessing the care they need. They include: Services are provided by multiple programs that do not share common goals. Parents and families have difficulty finding reliable information that can ensure the best care is available to their children and themselves. And elected officials do not consistently know which programs are working, which are not, and where the next few dollars should be spent.

The primary challenges facing children and families who need care are tied to funding and how services are organized. Separate human service agencies have distinct program goals because their responsibilities have been defined as mutually exclusive. Families are confused and frustrated because services are organized in ways that are confusing and frustrating. And policy-makers have no clear guidance because the system is so complicated and unmet needs so enormous. The result is public policy guided by small changes in policy or funding that are much easier to achieve than the right changes. And many small changes further complicate, confuse and frustrate.

As part of this report, and based on the Commission's previous works, this finding and recommendation outline a strategy to begin needed reform across multiple service systems and programs. The Commission is compelled to recommend such large scale reform because the present service delivery system fails so many families, at such great cost and consequence. This recommendation outlines the steps to redesigning that system.

Serve Children and Families

Finding 5: California does not fund, organize or administer services to comprehensively meet the needs of children and families.

Children and families need more than mental health reform. So many of the barriers they face to accessing appropriate care, are not part of "mental health" policy. They involve the educational system, child welfare programs, juvenile justice policies, foster care services, as well as other programs and policies.

The previous recommendations would improve the ability of the mental health system to provide quality, appropriate care. But they do not address the core barrier limiting the ability of California to improve care. California does not have a single system to serve children. Rather, it has multiple systems that do not work together and are often at odds. The complexity of these systems and how they interact frustrates parents, misses opportunities to prevent problems and reduces opportunities for improving services. This complexity drives up costs and diminishes the effectiveness of well-intended social programs.

The State and local agencies have begun to build integrated services around the needs of children and families. Service integration is intended to provide the following:

- ✓ Consistent care regardless of how the system is accessed.
- ✓ Comprehensive services to meet a full range of needs.
- ✓ Consistent care as children age or needs evolve.
- ✓ A single point of responsibility and accountability for outcomes.
- ✓ Services designed around long-term individual, family and community goals.

While integration offers great promise – and hope that services can be driven by needs, focused on prevention and cost-effectiveness – existing efforts have been limited.

- ✓ They have been implemented on a small scale, primarily for targeted populations, not for all children and families in need.
- ✓ Counties have assumed the majority of the risk associated with change and have received limited support from the State.
- ✓ Integration efforts have not removed administrative barriers that increase workload and bureaucracy.
- ✓ Integration has not allowed discretionary use of primary funding.
- ✓ Pilot programs and targeted integration efforts have not been taken to scale, limiting investment in building a true system of care.

California should commit itself to truly integrated services. Policy-makers should understand what has worked in the past, the progress of present efforts, and how to maximize the potential of this service delivery approach.

Ultimately, every county should build a single system of care for all children and families that is designed, funded, staffed and held accountable for ensuring that all children and families are safe, healthy, at home, in school/in work and out of trouble.

Recommendation 5: The Governor and the Legislature should ensure that no child or family suffers needlessly because state and local programs fail to work toward common objectives. The Legislation should:

- ***Establish policy goals.*** California must ensure that state and local policies and programs support the overall well-being of children and families. All public policies should be guided by the following goals: All children and families should be safe, healthy, at home, in school or in work, and out of trouble.

- ***Establish an innovation project.*** A five-year innovation project should allow local agencies to design a service delivery system to achieve the above policy goals. Innovation projects should designate a single county entity that is responsible and accountable for outcomes. The State should offer a range of support for counties interested in participating, including:

  - ✓ ***Planning grants.*** Some counties are ill-equipped to move forward without significant planning. The State should offer planning grants to support local efforts.
  - ✓ ***Technical assistance.*** The State should provide technical assistance to counties struggling to address issues of confidentiality, blended funding and other concerns.
  - ✓ ***Regulatory relief.*** The State should expand and streamline existing efforts to provide regulatory relief.
  - ✓ ***Discretionary funding.*** The State should buy-out any state, federal or other funding that restricts local efforts to integrate services.

- ***Create a Secretary for Children's Services***. In previous reports, the Commission has recommended a high-ranking official responsible for integrating disparate programs serving children and youth. The Commission reiterates that recommendation with a call for a Secretary of Children's Services.

- ***Form a multi-agency coordinating committee.*** The State should offer a single point of contact to counties. The coordinating committee, headed by the Secretary, should include representatives of all state entities responsible for assisting, funding and regulating agencies that provide services to children and their families. It should evaluate the innovation project and be charged with developing strategies for overcoming barriers to statewide policy goals for counties not participating in the project.

- ***Create mechanisms for local accountability.*** Local elected officials are ultimately responsible for the performance of county programs. The coordinating committee should identify measurable outcomes for the policy goals listed above. It should provide the guidance for local officials to develop uniform reporting mechanisms, and it should publicize outcomes.

Introduction

In November 2000 the Commission issued a report on mental health policy titled, *Being There: Making a Commitment to Mental Health*.[5] In that report the Commission argued that all who need care should receive high-quality, appropriate services paid for by the public and private sectors. The November 2000 report focused on how well California's mental health system serves adults. This report is a follow-up examination of how well children are served by the public mental health system.

In the earlier report, the Commission called for the creation of an advocacy commission to assess the costs of failed policies and champion reform. It recommended that the Governor and Legislature bolster the ability of the California Department of Mental Health to lead the State's community-based mental health system. The Commission recommended that mental health clients receive comprehensive care and that funding be used as a tool to promote improvements in the quality and efficiency of services.

Two recommendations relate specifically to adults in the criminal justice system. The first declared that no one should end up in jail or prison because of unaddressed mental health needs. The second advocated a continuity of care for clients returning to their communities after a period of incarceration.

Finally, the Commission asserted that the public and policy-makers need to understand how mental health services are performing. It called for the state Department of Mental Health to put into place an accountability system that has been long in coming.

Each of those recommendations applies to children. The philosophy that guided that report is equally true for children and adults. All who need care should receive the services and support they need.

This report is linked to the earlier report, but also is distinct. Children are not "little adults," especially when it comes to their mental health needs. And the children's mental health system is not a smaller version of the adult mental health system. Children have the same needs as adults, but fewer personal resources available to meet them. And because children are growing and developing, children's mental health care offers greater opportunities for prevention.

The Commission's interest in mental health policy is guided by the centrality of mental health services to achieving numerous publicly held goals. The Commission has recommended expanding mental health services for abused and neglected children.[6] It has recommended improved mental health assessments and treatment for prison inmates and those released on parole.[7] During its review of juvenile justice programs in 1994, the Commission examined the adequacy of mental health services for troubled youth.[8]

In this review, the Commission intended to examine whether children receive the care they need to recover. This was a more ambitious project than initially realized because of the complexity of the issues and the need for sophisticated solutions.

Californians should be proud to know that children who falter or fall can turn to an impressive array of programs to help get them back on the path toward healthy development. But they also must recognize that the efficiency and effectiveness of those programs could be improved. Thousands of children do not land in the safety net that was intended to catch them. And those that do may not receive the help they need.

The recommendations in this report are offered to the Governor, the Legislature and the people of California. The Commission intends these recommendations to support systematic reforms to the services provided to children and their families facing challenges they cannot overcome alone.

The report contains five findings and recommendations that would fortify the mental health system through three strategies:

- ***Ensure Appropriate Care.*** Thousands of children are falling through California's mental health safety net. State and local officials must ensure that each county has a continuum of services that can address the needs of the children in their communities. Children need access to preventive services and support. They must be able to rely on appropriate residential programs that can speed their recovery. And hospital and specialty care should be available to all children when and where it is necessary. Ensuring an appropriate level of care requires state and local leaders to assess needs, agree on standards for adequate services, and develop strategies to meet them.

- ***Build Capacity for Success.*** California's mental health system is facing significant barriers to its ability to respond to the diverse needs of children. Many of those barriers are tied to how services are funded and how they are administered. Mental health

resources are not allocated or organized in ways that promote prevention, program efficiency and continuous improvement. And state and local mental health leaders lack the support, training and resources they need to achieve publicly held goals for children. A related challenge is the availability of trained and qualified staff to care for the children in need of services. The State and local agencies must support the ability of mental health officials to be successful if they want children to receive high-quality, efficient care.

- ***Meet Comprehensive Needs.*** Improving access to appropriate services and building capacity will enhance the quality of care available to California's children. But a core barrier to success is how programs are organized. The programs available to children and families are not designed, funded, or held accountable in ways that reflect the comprehensive needs of children and their families. Significant improvement in outcomes, efficiency and the effectiveness of care will require California to rethink how it serves children and families.

The Commission began its work on mental health policy in September 1999 with a public hearing on the mental health service system and the challenges it faces. Three hearings followed in October 1999, January 2000 and October 2000. Public hearings allowed the Commission to hear from community members, policy analysts, mental health experts and others on how the mental health system operates, where it succeeds and how it fails. The hearings provide a public forum to surface issues, discuss ideas and consider recommendations.

The Commission also convened an advisory committee of experts to further explore mental health policies. The advisory committee included youth and young adults, parents, mental health professionals, program administrators, school and juvenile justice officials, and others. The advisory committee process allows the Commission to identify new issues and explore in more detail topics identified during public hearings.

The hearings and advisory committee meetings were complemented with site visits and focused discussions with youth and young adults, parents, community organizations and professional associations. These meetings enabled the Commission to explore how children and their families, mental health staff and other professionals see the challenges in the mental health system.

Throughout its work, the Commission benefited from the commitment and contributions of more than 100 people who took time from their busy lives to invest in the Commission's review. The Commission is particularly thankful for the opportunity to meet and talk with the young

adults from the California Youth Connection and with the youth and young adults at Metropolitan State Hospital. Their brave and open discussion of what's working and what is not guides much of this report.

The Center for Mental Health Services Research at UC Berkeley and UC San Francisco also provided considerable advice and technical assistance. The Center provided invaluable guidance as the Commission explored specific aspects of this study. As always, the Commission greatly appreciates this assistance, but the conclusions are those of the Commission alone.

Background

Children and families in need of mental health care face a daunting array of issues that delay or hamper their ability to receive the care they need: Who to turn to for assistance. How to pay for care or access publicly funded services. How to know if the services offered are the right services rather than the only available option. And how to judge the quality of their care.

These issues arise because the science of children's mental health is evolving. The professions that care for children with mental health needs are in flux. And public programs to serve children have been developed over many decades through incremental policy and funding decisions that have created a tangle of offices, departments, agencies and service providers.

This environment magnifies the challenges of understanding, evaluating and improving children's mental health policy. There is disagreement over where mental health stops and mental illness starts. There is confusion over who provides, funds and makes decisions regarding mental health care. And the politics of resource allocation, professional privilege and science cloud discussion of these issues.

Where Mental Health Stops And Disorders Begin

Perhaps the greatest challenge facing mental health policy is to understand what constitutes mental health and what it means to experience a mental illness. According to the U.S. Surgeon General, the distinction between mental health and mental illness is not clear.[9] Mental health and mental illness are defined according to sets of indicators, which vary among different people. Age, gender, ethnicity, cultural background and practice, and socioeconomic status influence social understanding of these indicators. When behavior, thought processes or perceptions diverge from normal expectations for these indicators, mental illness may be the cause.

This lack of clarity about mental illness complicates policy decisions. Public policy is often charged with establishing formal responses to formal conditions. Developing good policies is particularly challenging when science and society offer inconsistent perspectives regarding what constitutes illness, when and where public funds and resources should be used, and what outcomes can be expected.

The U.S. Surgeon General reports that mental health and mental illness are tied to social, psychological and biological factors.[10] Social factors include how people respond to stress, their ability to deal with adversity, and the social support they have available to bolster their resilience.[11] Psychological factors include personality differences and temperament.[12] Biological factors include genetic disposition to mental illness, the formation and development of the brain and how it processes information.

Experts do not consistently agree on the conditions that result in mental illness. One concern driving the disagreement is that not all people experience mental illness in the same ways or under the same conditions. Some people respond to traumatic events better than others. The complex interplay between personal experience, environment, biological influences, and other risk factors that may account for an illness is not clearly defined.

New research, for example, has renewed focus on brain development and biological links to mental illness.[13] Advancements in understanding the brain have encouraged some to argue that mental illness is primarily tied to brain dysfunction. Others assert that social and psychological factors are equally if not more significant, because the brain often adapts to social conditions. Still others suggest the distinction between social, psychological and brain-derived factors is not useful because the brain changes in response to experience.

Determining when mental illness begins is significant in deciding when and how to promote prevention and provide treatment. Further confusing the issue, some people are able to overcome the stresses and challenges they encounter in life without ever relying on professional care. Other people become debilitated and require more focused, concentrated services, often for conditions that would not diminish the ability of others to successfully cope and function.

This variation in how people respond to the risks and symptoms of mental illness has lead practitioners to focus on severity and persistence of symptoms, rather than simply their existence. Given the complexity of determining what mental illness is and how it affects individuals, it is even more difficult to describe mental health and how to encourage people to thrive. Yet the impact of significant illness on people's lives and functioning is clear as are the costs of unaddressed mental health needs in both economic and human terms.

In general, individuals who experience significant symptoms and impaired functioning in some or all areas of their lives - such as their ability to function at home, in school, at work or in their community - are

those most often recognized as experiencing mental illness. People with no apparent limits to their functioning typically are considered to have less serious impairments. Many of these individuals struggle with mental illness only with enormous effort. They are able to overcome significant impairments in one area of their lives but often at the expense of other areas. The extreme effort to manage symptoms in one part of a person's life can overwhelm limited emotional resource and lead to failure in other parts of life.

Children and Mental Health

A child's development, from birth to adulthood, is a period of profound transformation. Just as children develop physically—growing taller and stronger, gaining increased coordination and new physical features—they develop emotionally, socially and intellectually. A mentally healthy child meets emotional, social and intellectual milestones just as a physically healthy child meets physical milestones of height, weight and physical functioning. Children who meet these milestones function well and appropriately for their age at home, at school and in the community. They thrive and prosper without symptoms that comprise their ability to learn and grow.[14]

The mental health of children is evaluated based on how well they meet these milestones. Developmental milestones are the indicators used to evaluate whether a child is mentally healthy or not. To understand the developmental milestones of children, these indicators must be viewed in the context of the child's environment, which includes their family, peer group, school and larger physical and cultural surroundings.[15]

For instance, normal child development can involve temper tantrums and other behavior that strain the patience of parents and other caregivers. Aggressive behavior, biting, and destructive and dangerous play can all have their place in the normal development of children learning how to interact with parents, siblings and their environment.

But when tantrums become commonplace or continue past the age where they are acceptable, when dangerous play becomes a daily event, or when children fail to transition through conventional social and emotional milestones, their behavior could be linked to a mental health problem.

Object Permanence: Playing Peek-A-Boo

Peek-a-boo is a common game played between parents and infants in the United States. This simple game actually helps to teach an important lesson to a child's developing brain. It teaches them to understand that their mother, father, or significant caregiver exists even when they are out of sight. This lesson is called "object permanence." Children who fail to learn this critical lesson will have a more difficult time developing positive social relations, strong coping skills and self-confidence.

Source: Y. Munakata, J.L. McClelland, M.H. Johnson, R.S. Siegler. 1997. "Rethinking Infant Knowledge: Towards an Adaptive Process Account of Successes and Failures in Object Permanence." Psychological Review. 104:686-713.

The term "mental illness" is usually applied to adults with diagnosed illnesses such as major depression, manic-depressive psychoses and schizophrenia.[16] Although some disorders of childhood may be early signs of such illnesses, the more frequently used terms, in federal and state policy, for the psychological or psychiatric problems of childhood are "emotional disorder," "behavior disorder" or – most frequently – "emotional disturbance." As in adults, childhood mental health and illness are linked to biological, social and psychological factors. It can often be unclear what specifically causes a childhood mental disorder.

Biological factors can include genetic dispositions, exposure to toxins—such as a mother's use of drugs while pregnant—or an anomaly in the structure of a child's developing brain.

Social factors include learned behavior. A child who learns that destructive behavior is rewarded can develop behavior patterns that meet diagnostic criteria for a mental illness. Equally, a child who fails to learn appropriate lessons—such as learning that a parent does not cease to exist when out of direct sight—can miss important developmental milestones.

Psychological factors can include trauma, stress or other influences that disrupt a child's normal development. According to the U.S. Surgeon General's report, events such as child abuse and neglect often lead to mental illness.[17] Some argue these events should be considered contagious diseases that can be passed down through families.

Prevalence of Mental Health Needs

Because there is debate about when symptoms constitute an illness, it is difficult to count the number of children affected. As a result, severity indices and prevalence ranges take the place of discrete counts.

In general, about 10 percent of all children experience conditions that warrant a diagnosable mental illness with some form of impairment.[18] But prevalence rates vary for children by age. Few studies have examined mental illness in children under five years of age because few

clinicians are trained to recognize these conditions and many symptoms are confused with normal childhood behavior. [19]

Common Mental Disorders

Normal childhood behavior includes a range of behaviors that can look like disorders. Children are considered to have a mental disorder when that behavior is severe or impairs their ability to function according to expectations.

Mental illnesses are generally categorized by types of disorders. The following examples illustrate variation in the types of illnesses that children can experience. The cause, treatment and duration of these disorders vary. A range of common childhood disorders is described below, along with an example and illness from each category.

Anxiety Disorders. These disorders reflect feelings of anxiety or fear causing distress or affecting relationships, academics or work.

> **Separation Anxiety Disorder**. Children may cling to their parents or fear that their parents will become ill or die. This disorder can cause depression, nightmares and nausea.

Adjustment Disorders. Symptoms of these disorders include depressed or anxious mood, physical complaints or conduct disturbances. These disorders are associated with stressful periods in the child's life. Symptoms usually occur within three months of the event and typically last no longer than six months.

Attention Deficit/Disruptive Behavior Disorders. Symptoms of these disorders include frequent and severe inattention and hyperactivity that limit a child's ability to succeed in school and function socially.

> **Attention-Deficit/Hyperactivity (ADHD)**. Children who cannot pay attention when attempting or completing tasks or at play, children who fidget or squirm with hands or feet, and/or impulsively blurt out answers or comments in class or at home.
>
> **Conduct Disorder**. Children who are physically violent to humans or animals, destroy property, are preoccupied with using weapons, and defy rules associated with school, home and other authorities.

Developmental Disorders. Children with these disorders have extreme difficulty interacting socially, including communicating.

> **Autism**. Children may be aggressive, have temper tantrums, have a high threshold for pain, be overly sensitive to light or sound, and have difficulty communicating to the point of not speaking.

Mood Disorders. These disorders are associated with long periods of loss of interest, irritability and/or feelings of intense elation followed by depression.

> **Depression**. The most common mood disorder diagnosed in children is depression. Children with depression are usually sad and often criticize themselves. They feel unloved and hopeless about the future. They may have trouble sleeping and concentrating in school. Suicide is commonly associated with depression.

Other disorders include eating disorders, elimination disorders, learning and communication disorders, and schizophrenia.

Source: American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders. (4th ed.) Washington, DC.: American Psychological Association.

A national review of studies on the prevalence rate of mental illness for children of all ages suggests the following illustration of how many children in California experience mental health needs:[20]

Age	Number
0 to 4 year olds	313,517
5 to 9 year olds	410,809
10 to 14 year olds	349,783
15 to 19 year olds	408,416

Like physical illnesses, some mental illnesses are more common than others. Some form of depression is evident in 10 to 15 percent of children at any one time. Major depression is seen in between 0.4 and 2.5 percent of adolescents in any given year.[21] Attention Deficit/Hyperactivity Disorder is seen in 3 to 5 percent of school age children.[22] Anxiety disorders – which include separation anxiety disorder, social phobia and obsessive-compulsive disorder – are seen in 13 percent of children ages 9 to 17.[23] Developmental disorders, such as autism, are seen in about 0.1 to 1.2 percent of children.[24]

Responding to Mental Health Needs

Many people are unaware that mental illnesses are treatable. Different treatment approaches are used to respond to different needs. Many children and families benefit from multiple treatment approaches that are combined in a package of services. Some of these "service packages" are given names and proliferate as they become popular. The following list is not exhaustive, but illustrates the range of services and service approaches that are available.

Treatment Modalities:

Psychotherapy "Talk Therapy." Clients and psychotherapists discuss issues to help clients develop a clearer understanding of their needs and how to better manage them. There are multiple variations in how psychotherapy is used to assist clients.[25]

Pharmacological Therapy "Drug Treatment." Recent advances in understanding how the brain and body function have advanced the availability of drugs that can address mental illness.[26]

Treatment Formats, Approaches, Venues:

Outpatient Treatment. Outpatient treatment is the most common form of mental health treatment. Children may respond to a variety of non-residential, non-hospital treatment approaches. There are numerous outpatient treatment strategies, many proven to be effective, others of uncertain value. Standards have not been established to distinguish between what works and when, and what does not.[27]

Common outpatient treatment approaches include:

- ***Cognitive Behavioral Therapy***. Cognitive behavioral therapy examines how a person thinks and what that person does to encourage adaptive behavior. The therapy tries to change self-statements from "I can't do that" to "I can do that."[28]
- ***Family Therapy***. Family therapy is a way for families to explore shared problems, sources of stress and other challenges family members may be facing.
- ***Self-Help.*** Self-help brings together people to share their experiences, and common issues to find peer support not generally available from professionals or outsiders.[29]

Ritalin and Attention-Deficit/Hyperactivity Disorder (ADHD) Concern for the Overmedication of Children

In recent years clinicians have expanded the use of drugs to treat children who have mental health needs. Growth in drug treatment for children has caused alarm among parents, psychiatrists, child advocates and others. They allege that many children are being prescribed medications for conditions that do not warrant them. The explosive growth in the prescription of Ritalin (methylphenidate) has driven much of this debate. Activists point out that the supply of methylphenidate has grown by 250 percent in the last 10 years. Federal officials argue that increased use is linked to better diagnosis and awareness of ADHD in the child population.

The U.S. Surgeon General points to three areas where research has not kept pace with drug treatment practices:

1) For most prescribed medications, including those used in physical health treatment, the safety and efficacy of drugs have not been adequately studied for children.
2) There is limited information on how prescribed medications can build up in the tissues and body fluids of children.
3) The combined effects of prescribed medications and psychosocial treatment has not been adequately studied.

These knowledge gaps and the increasing use of drugs to treat children is cause for concern. Research suggests that the majority of drugs prescribed to treat mental illness in children are not prescribed by child psychiatrists, but are prescribed by pediatricians and family practitioners with limited training and ability to appropriately diagnose mental illnesses.

Source: U.S. Department of Health and Human Services. 1999. Mental Health Report: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Pages 149-150.

Continuum of Care

A continuum of care represents the range of services, programs and supports necessary to ensure that children and families receive all the care and services they need, when and where it is most effective and efficient.

An appropriate continuum of care is designed to prevent the escalation of needs, costs and suffering.

- ***Case Management.*** Case management involves the coordination of multiple services for children and families receiving care and support from a number of sources. Case managers aid families struggling to navigate programs across multiple departments or agencies.[30]

- ***Wraparound.*** Wraparound is a form of case management that involves clients and their families in developing a treatment and support plan that builds on personal and family strengths. Wraparound is commonly used in California to help children remain in their homes and avoid the need for residential treatment.[31]

- ***Multisystemic Therapy (MST).*** MST offers a focused, short-term approach to working with children, their families and community organizations to address severe emotional disturbances. MST teaches children, school officials, family members and peers to identify and address factors leading to problem behaviors.[32]

Many Problems, Many Agencies

Children with mental health needs often are served by multiple public agencies. Many children have co-occurring needs. They may need mental health care, as well as substance abuse treatment or support for a developmental disability. Some become involved with the juvenile justice system. Treatment approaches for children with co-occurring needs are distinct from those for children with singular needs.

Common co-occurring disorders include:

Substance Abuse. National studies report that 41 to 65 percent of the people with a lifetime substance abuse disorder also have a history of at least one mental illness. Conversely, about 51 percent of people with a lifetime mental illness have at least one substance abuse disorder. Children ages 15 to 21 have the highest prevalence of co-occurring substance abuse and mental health disorders. Research has not clarified why mental illness and substance abuse are co-occurring, but suggests that drug and alcohol are used to address the symptoms of mental illness.

Developmental Disorders. Many children have co-occurring mental health and developmental disorders. Services for children with developmental needs are provided through California's Department of Developmental Services and not through state or local mental health programs.

Juvenile Delinquency. Research suggests that as many as 90 percent of the children in the juvenile justice system have a diagnosable mental illness. Some argue that because definitions of mental illness are tied to behavior, the behavior that lands a child in a juvenile facility is the same behavior that constitutes the illness. Others point out that because of their detention, children suffer depression, learning, emotional and anxiety disorders. The link between mental illness and delinquent behavior has not been clarified. Some children are arrested as a consequence of unaddressed symptoms: inability to control impulses or learning difficulties lead them to disrupt school or social settings. Other children may experience depression, anxiety or other symptoms because they have been removed from their families.

Some of these issues are detailed in the Commission's June 2001 report: *Never Too Early, Never Too Late: To Prevent Youth Crime & Violence*.

Residential Treatment. Some children require treatment through residential programs. In some cases they are unable to remain in their home because they have been victims of abuse or neglect. In other cases children have needs that cannot be addressed by their parents or other caregivers and residential treatment offers a more appropriate treatment environment.[33]

State law prohibits county mental health or social service departments from operating residential treatment programs, therefore they are operated by private organizations. California has for-profit and non-profit residential facilities. The Department of Social Services licenses 13,481 residential treatment "beds" in California. The type of license a facility holds determines the children who can be served. Facilities range from level 1 to level 14. Levels define the staffing required to provide particular services and the funding each facility receives.[34]

Crisis Services. Crisis services play an important role in a continuum of care for children and families. They offer immediate response to a situation that could be life-threatening or lead to other significant consequences. Crisis services generally include assessment, stabilization through brief and intensive treatment, and a link to follow-up care.[35]

Suicide

Experts say that one out of every 100 suicide attempts is successful and 90 percent of child suicide victims had a mental illness or a substance abuse problem. Children as young as 5 have been known to attempt suicide.

The incidence of suicide has tripled over the past 40 years, from 4.5 per 100,000 to 13.3 per 100,000. Some experts suggest that one child out of every four considers suicide at least once each year and one in 10 attempts suicide each year, with parents and teachers unaware of their behavior.

Most victims experience clinical depression, and few receive adequate mental health care.

Source: U.S. Department of Health and Human Services. 1999. Mental Health Report: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Pages 150-151. Roger Trent, Ph.D. "Information on Suicide in California." A presentation to the California Suicide Prevention Advocacy Network. January 20, 2001. On file. Rebecca Jones. 2001. "Suicide Watch." American School Board Journal. May 2001. Pages 16-21.

Day Treatment/Partial Hospitalization. Day treatment allows a child to receive care that is equivalent to hospital or other inpatient care, while returning home at night. Day treatment generally provides more structured services than are available through most outpatient programs without the family disruption of residential care.[36]

Hospitalization. Hospital-based care is an important component of a continuum of care. Children are referred to hospital care for crisis or emergency room services, for short-periods of intense care or for stabilization.[37]

Mental Health as Public Health

Over time, practioners have increasingly turned to the public health approach to guide how they respond to mental health needs.

The public health approach seeks to understand and maintain good health within the population. It prioritizes research and draws upon diverse bodies of knowledge and strategies to reduce disease and promote health. It promotes prevention as an effective strategy to reduce the incidence of disease and the need for services.[38]

Researchers have identified a range of circumstances – including neglect, abuse, and prenatal drug use – that threaten a child's mental health and can lead to immediate and long-term mental health needs.

Risk and Protective Factors

Under a public health approach, researchers attempt to understand what risks are associated with developing a mental illness. As discussed above, mental illness is linked to psychological, social and biological risk factors. Distinct from causes, which remain unclear, there is ample evidence that mental health is threatened by factors such as exposure to violence, abuse and stress. Research is documenting how biological factors such as brain structure and function are linked to mental illness, as well.

Identifying Risk Factors

The U.S. Surgeon General has documented a variety of factors that put children at risk of needing mental health services. Not all children exposed to these factors will develop an illness. They merely increase the chance that mental illness may occur. Risk factors include:

- ✓ Prenatal exposure to alcohol, illegal drugs, or tobacco
- ✓ Low birth weight
- ✓ Family history of mental illness
- ✓ Malnutrition
- ✓ Abuse and neglect
- ✓ Stressful life events such as divorce, death of a parent or exposure to violence

Children who experience similar risks do not all respond alike. Some develop illnesses, while others do not. Research is revealing that protective factors can diminish the influence of risks and reduce the likelihood a child will develop a mental illness.[39] Prevention efforts, therefore, focus on reducing risks and enhancing protective factors.

Protective factors reflect how a person responds to risks. They can include personal, familial or community resources that can diminish risks. Protective factors might involve one's ability to respond to stressful life events. Having a supportive family reduces the likelihood of experiencing long-term effects of violence, trauma or abuse. Protective factors also can include community resources such as church or social supports that increase a person's resiliency.[40]

California's Children's Mental Health System

California's mental health system has evolved over the last four decades. This evolution has changed the role of the State and local governments in providing care. Mental health services have moved from being predominately hospital-based and provided by the State to community-

based and provided through local governments. More recently, mental health stakeholders have recognized that mental health care requires an array of services that have not traditionally been available through a community-based service model.[41] For instance, institutional care provides housing, social activity, vocational rehabilitation and physical health care. Community mental health programs have historically not provided housing, social activity, vocational rehabilitation and other services that can be important in helping a person address their needs and live independently.

Early Childhood Prevention Initiatives

As the benefits of prevention have been documented, policy-makers have sought to improve the ability of very young children to access care. Research in early childhood development and education demonstrates the value of early efforts to promote school-readiness in children. Successful programs have been shown to reduce costs and improve learning, health and overall development. Some early childhood programs have been shown to reduce involvement with the juvenile justice system later in life.

California has supported a number of initiatives to improve the ability of parents, child care and other professionals to respond to children with mental health needs. These initiatives include:

California Early Intervention Technical Assistance Network (CEITAN). CEITAN is funded by the California Department of Developmental Services to provide training, technical assistance and support for programs providing early intervention services to children with developmental disabilities and their families.

Early Mental Health Initiative (EMHI). Funded through the Department of Mental Health, EMHI is intended to enhance the social and emotional development of young students and minimize the need for more costly services as they grow older.

Infant-Preschool & Family Mental Health Initiative (IPFMHI). Through the IPFMHI the California Department of Mental Health funds programs in eight counties to develop early mental health services and relationship-based early intervention for children from birth to 5 years of age and their families.

California Early Start. Early Start provides early intervention services to children from birth to 3 years old who have developmental disabilities or who are at risk. Early Start was created to support the ability of families to meet the developmental needs of their children with developmental disabilities.

California Child Care Mental Health Project. The California Department of Mental Health in 1999 allocated funding to three counties to improve coordination between mental health and child care programs. The goal is to improve the ability of child care professionals to serve children with challenging behaviors by linking them with mental health professionals. State funding has ended but the counties have continued to support the projects.

California Children and Families Commission and local Commissions (CCFC). Created by Proposition 10, the CCFC and a commission in each county are intended to support education and services to children ages birth to 5 years old and their families. The state commission has developed a *Kit for New Parents* that will be distributed to 500,000 new parents throughout California.

Sources: California Early Intervention Technical Assistance Network (CEITAN). For more information, contact the Infant Mental Health Development Project at WestEd in Sacramento, California.; Early Mental Health Initiative. For more information, contact the California Department of Mental Health.; Infant-Preschool & Family Mental Health Initiative. For more information, contact the California Department of Mental Health and WestEd in Sacramento, California.; California Early Start. For more information, contact the California Department of Developmental Services.; California Child Care Mental Health Project. For more information, contact the California Department of Mental Health or Alameda County Behavioral Health Care Services.; California Children and Families Commission and local Commissions. For more information, visit the state commission's Web site at www.ccfc.ca.gov.

Multiple state agencies provide health, mental health and related services. The primary agency for ensuring the provision of mental health services is the Department of Mental Health. It operates state hospitals, oversees county-based mental health services and is charged with providing leadership on issues of policy and practice. The Department of Health Services is California's lead agency for Medi-Cal, which funds treatment services for some children. The Department of Alcohol and Drug Programs, Department of Social Services, Department of Rehabilitation and the Department of Education each offer services or coordinate programs available to children with mental health and related needs.

The primary public providers of mental health services are California's 59 local mental health agencies, the majority run by county governments.[42]

The Commission's November 2000 report on mental health explains in detail the organization of the Department of Mental Health, and the organization and funding of community-based mental health care.

Milestones for Children's Mental Health

1957 – California establishes community mental health services. The Short-Doyle Act of 1957 (Chapter 1989) provided state funding to support the development of community mental health services. Most adults and children with mental health needs were served through psychiatric institutions, many run by the State.

1978 – California passes Proposition 13. Proposition 13 changed the nature of local government financing. Limits on property tax levels restricted the ability of county governments to raise local revenues. Consequently, locally funded services, including mental health programs, were severely impacted and became more dependent on State appropriations.

1978 – Each county is directed to establish a coordinator and an advocate for children's mental health programs. Concerned that children were receiving inadequate care in community mental health programs, the California Department of Mental Health urged each county to designate a coordinator for children's mental health programs and a children's advocate on community mental health boards.

1978 – State establishes community residential treatment system. AB 3052 (Chapter 1233, Bates) directed the Department of Mental Health to develop a grant program to allow counties to develop

community residential treatment systems for children and adults as an alternative to institutional care.

1978 – State Department of Mental Health promotes improved training for children's mental health professionals. The Department of Mental Health, in partnership with UC Berkeley and UCLA, implemented a training program for children's mental health specialists. The training was intended to improve the ability of practitioners to use strength-based and habilitative approaches when working with seriously emotionally disturbed youth.

1978 – State adopts standard for children's mental health funding. AB 1339 (Chapter 1228, Egeland) established that a minimum of 25 percent of local mental health funding should be dedicated to meeting the mental health needs of children.

1979 – Local children's mental health coordinators create informal association. Recognizing shared concerns for the availability and quality of care for children, local mental health coordinators met informally to discuss shared concerns and policy options.

1979 – State directs local mental health agencies to provide community care for institutionalized persons and to promote prevention. AB 7 (Chapter 557, Egeland) amended the Short-Doyle Act to direct local agencies to design community services around the needs of people who are institutionalized or at risk of institutionalization. The legislation also directed the Department of Mental Health to report the extent that counties are pursuing mental health prevention strategies.

1979 – The Department of Mental Health is directed to develop data system and lead statewide prevention program. AB 1438 (Chapter 1172, Bates) directed the Department of Mental Health to design a statewide system of data collection and analysis of mental health information and to prepare a statewide prevention program to reduce the need for treatment services, to strengthen community support for mental health care and to support the development of self-help networks.

1980 – State Department of Mental Health sponsors children's mental health conference. Increasing interest and concerns for children needing mental health services lead the Department of Mental Health to convene a conference for children's mental health coordinators.

1982 – Legal decision directs school districts to fund residential services for children in special education programs. Known as the Christopher T. decision, the court held that school districts are required to pay for residential placements if a placement can help a child in a special education program benefit from a free and appropriate public education. Two years later the Legislature provided funding for residential placements for special education students through Assembly Bill 3632 (see below).

1982 – State directs local mental health, welfare and probation programs to coordinate services for children served by multiple programs. AB 2315 (Chapter 325, Lockyer) required county mental health, welfare and probation programs to work together to address the needs of children in out-of-home placements who have mental health needs.

1984 – California implements Christopher T. court decision and establishes that children in special education programs have right to free treatment services if those services can promote educational goals. AB 3632 (Chapter 1747, W. Brown) directed community mental health programs to provide assessments, treatment and case management services to children in special education programs. The court case and legislation also required county mental health programs and schools to work together to meet the needs of children.

1984 – State funds a pilot system of care approach to serving children in Ventura County. AB 3920 (Chapter 1474, Wright) directed the Department of Mental Health to contract with Ventura County to establish a pilot program that would provide comprehensive mental health services to children.

1987 – State extends system of care program to additional counties. AB 377 (Chapter 1361, Wright) established the statutory framework to extend the system of care approach to providing services to all counties. Between 1987 and 2001 all but a handful of counties received State System of Care funding.

1989 – Congress establishes comprehensive prevention and treatment program for all children enrolled in state Medicaid programs. The federal Omnibus Budget Reconciliation Act amended the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit in the federal Medicaid program. The amendment requires all states to screen children under age 21 to determine their health care needs, including mental health needs, and provide any Medicaid eligible services necessary to address those needs.

1991 – California reforms the organization of State and local financing for public social services. AB 1288 (Chapter 89, Bronzan) implemented sweeping changes in the organization and financing of public social services, including mental health care. Known as Realignment, these changes stabilized mental health funding, gave counties greater control over spending decisions and established criteria for prioritizing who would be served.

1991 – California establishes mental health prevention program for school children. AB 1288 (Chapter 89, Bronzan) established the Primary Intervention Program (PIP) as a statewide early detection program for children in grades K-3. PIP provides play therapy and other services to young children at risk of experiencing emotional, behavioral, and learning difficulties.

1992 – California revises its state Medicaid plan to cover a greater range of services. The Department of Health Services amended California's Medicaid plan under the federal Medicaid program to allow Medi-Cal participants to receive mental health and related services in a greater variety of settings, including community and home-based care. Prior to the revision, Medi-Cal services were primarily available through office or clinical settings.

1993 – The Department of Health Services loses lawsuit over its failure to comply with federal EPSDT requirements. Children's advocates prevail in Smith v. Belshe, a lawsuit charging the Department of Health Services had failed to provide the full range of EPSDT services to children enrolled in Medi-Cal, as required under federal law.

1995 – California consolidates two mental health funding programs under Medi-Cal into a single Medi-cal Managed Care program. Prior to 1995 Medi-Cal participants could receive mental health services through two programs, the Fee-For-Service Medi-Cal program and the Short-Doyle Medi-Cal program. Consolidation required each county to develop a local mental health managed care plan that would serve all Medi-Cal clients. One effect of the consolidation was to increase the responsibility of counties to provide necessary mental health services to children.

1995 – California implements EPSDT benefit stipulated in Smith v. Belshe lawsuit. Beginning in 1995 the State provided additional funding to counties to implement federal requirements for screening, treatment and other services required under the federal EPSDT program for children.

Ensure Appropriate Care

Finding 1: Too many children suffer through mental health needs without the benefit of appropriate, compassionate and holistic care.

Every child deserves a healthy start in life. Public policies prioritize physical health with prenatal care, well-baby visits and other efforts to ensure that babies grow up physically healthy. But there is no parallel investment in children's mental health. Childhood is a period of intense physical, intellectual, psychological and social transformation. To ensure that children succeed, California must address all aspects of their development.

Many children who fail in school, end up in the criminal justice system, experiment with illicit drugs, abuse alcohol, or become teenage parents have mental health needs that have gone unnoticed or unaddressed.

Only 25 percent of the children identified with serious emotional or behavioral disorders graduate from high school with a diploma.[43] Many children with mental health needs end up in independent study programs because school districts have not developed appropriate programs to support their learning.[44] Overall, more children are turned away from the public mental health system than are served.[45] As a result, thousands of children and their families suffer needlessly because mental health care is unavailable. In the end, the lack of timely and adequate care costs taxpayers millions of dollars in additional criminal justice, education, and health costs – while at the same time diminishing the economic potential of these young people.

Hardworking Professionals in a Dysfunctional System

Thousands of dedicated mental health professionals go to work everyday to help, to heal and to save children and families who are suffering from mental health and related needs.

They toil for the right causes, but are frustrated in their efforts by a system designed to be inflexible, to discourage innovation and to punish risk-takers. Improving mental health care will require supporting these professionals with a system that rewards innovation, efficiency and responsiveness.

Every child with mental health needs should receive appropriate, compassionate and holistic care. All children should have access to a continuum of services that prioritizes prevention, responds early to needs, and provides services that support their healthy development, sound education and future success. Providing these services will necessarily require a combination of publicly and privately financed care. Parents, clinicians – and increasingly state and local policy-makers – recognize that the present mental health system fails to serve the very people it was intended to help.[46] Holistic reform is needed to develop a complete and vibrant system of care.

Who Gets Care

Children can access mental health services through a number of public services. For children from low-income families, Medi-Cal provides the easiest access to care. After Medi-Cal, the most significant source of funding is special education programs, which provide health and mental health services to children to help them improve their learning. County mental health and juvenile justice programs, school districts, and other programs also provide mental health services to children. Appendix C provides a list of many funding sources.

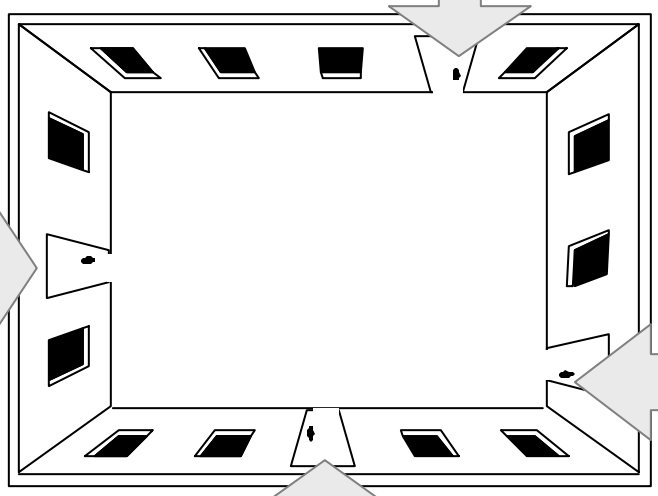
But each of these programs also has eligibility criteria that limit who can receive services. And many programs are administered in ways that prevent them from reaching everyone they are intended to reach. More than 1 million children who qualify for public health programs are not enrolled, and children on Medi-Cal lose their eligibility when they are detained in juvenile justice facilities.[47]

Child Welfare Services/ Foster Care

Children served by local child welfare agencies, including foster care, can receive mental health and related care. More than 100,000 children are in California's foster care system. Nearly 70 percent of these children will experience a mental illness associated with their placement or the circumstances that lead to their removal from their homes. The Department of Mental Health reports that significant numbers fail to receive the care they need.

Juvenile Justice

From 50 to 80 percent of children involved with the juvenile justice system have a mental illness. Federal regulations prohibit the use of Medi-Cal funding to serve children in juvenile justice facilities. Some counties tap grants or other funds to provide care to these children.



Schools

Some school districts in California provide mental health services through partnerships with mental health agencies. School-based mental health care is increasingly popular because schools provide a ready-made forum for serving children who might be struggling academically because of unaddressed mental health needs.

Social Services

Counties are required to provide substance abuse and mental health services to families participating in CalWORKs. Services are available for adults and children if those services would permit a welfare recipient to become employed.

Source: On file.

Barriers to High-Quality Care

As with many social services, providing high-quality mental health care to everyone in need is fundamentally an issue of resources. With unlimited resources, California could provide unlimited care. Part of the State's long-term strategy needs to be the identification of additional private and public resources to respond to unmet needs. Still, within the existing resources a number of barriers limit access or quality of care. Some of those barriers are created by how the funding is allocated; those issues are described in Finding 2. A number of primary barriers, however, are created by how programs are fashioned in law and administered by state and local agencies.

Even in the children's mental health system, California rations care

The public mental health system for adults deliberately and openly rations care by turning clients away until their symptoms are severe. A number of mental health programs for children, presented as universal and preventive, create the perception that children in need are served at the earliest opportunity.

The public mental health system in California serves more than 150,000 children each year, and many of those children are well served. But while roughly 10 percent of children in California need mental health services, just 3 percent are served by the public mental health system.[48] Clearly some children are served though non-public programs, but there is no evidence to suggest the remaining 7 percent are receiving care. Even among Medi-Cal clients – who are entitled to public services – only 5 percent (half of what could be expected) received services in 1999-2000. In 21 counties, fewer than 5 percent of these children received mental health services.[49]

These figures mean that for the average school in California with 691 students, 69 children will need mental health services, but only 21 will receive the care they need.[50] Some will suffer in silence; others in ways that cannot be ignored. They will drop out of school, end up in foster care or become involved in crime and violence. The bottom line: An estimated 600,000 children in California fail to receive the mental health care and support they require.[51]

For children who are not enrolled in Medi-Cal, most programs limit services to those with serious emotional disorders, often requiring a child to be diagnosed with a disorder that is on an approved list before care is available. For children with less acute, less debilitating needs, or just

those who have trouble seeing a doctor to obtain the necessary diagnosis, care is not available.

Leadership capacity is not always adequate

Some county leaders pursue federal and state funding more aggressively than others. They find a way to leverage, blend and draw down new resources. Some administrators bring in experts from around the country to help them understand the challenges and opportunities inherent in running a public mental health system. Other counties are less forceful and less resourceful. In these counties, available funds are more quickly exhausted and the smallest of administrative hurdles are allowed to diminish the numbers of children served and the quality of care they receive.

A Leadership Challenge

Verne Spiers, chief probation officer for Sacramento County, described the challenges of serving children with needs that are not severe enough to warrant their placement in a mental health facility, but too severe to ignore:

One example is a 15-year-old girl with a diagnosis of clinical depression, a history of sexual abuse, dysfunctional family, and 600 days in confinement at a detention facility over a three-year period. The court orders the minor into placement. The probation officer places her in a facility. She runs away, ends up on the street involved in drugs and prostitution, and within a short period is picked up, returned to juvenile hall and then court-ordered back into placement without having an opportunity to deal with her problems. Her predicament is not unlike many others.

The challenges presented by this example are repeated nearly each day in every county. Meeting this challenge will require local leaders to define shared goals and develop shared strategies. In some counties, mental health officials are working with local law enforcement, court officials and community partners to make sure no adult goes to jail if the mental health system can offer an alternative response. Similarly, county probation departments could talk with the district attorney, judges and county mental health leaders to make sure no child is sent to juvenile hall if mental health can provide a better response.

In some instances, inadequate leadership results in not using the latest information or relying on proven practices. In many counties, very young children fail to receive care because traditional diagnostic criteria were developed based on the needs and patterns of older children. Funding that is tied to an approved list of diagnoses based on the Diagnostic and Statistical Manual, Version IV (DSM-IV) of the American Psychiatric Association, can be harder to access for children ages 0 to 3. A newer reference that applies to these children, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC 0-3), is unfamiliar to many practitioners. Many parents and mental health professionals are unaware of efforts to link DC 0-3 diagnoses to the DSM-IV to permit the use of public funds to serve younger children.[52]

Human resource challenges also create a number of more routine barriers. Many counties have difficulty finding staff experienced with the complicated billing requirements of public funding. The push to implement new or expand existing programs overtaxes administrative workers. And the shortage of mental health professionals increases the workload and the frustration of those in the field.

Agencies fail to integrate efforts

Providing high-quality care requires the focused dedication of individuals and agencies whose primary charge is not mental health. For instance, children who qualify for special education services are entitled to support programs that can help them learn. Yet parents argue that requests for services are ignored, timelines established under the law are dismissed and school districts fail to notify them of their rights or the rights of their children to receive care.[53]

About 0.3 percent of California's school-age population in special education receives mental health care through programs for emotionally disturbed youth. That is less than one-third of the national average.[54] Protection and Advocacy, Inc. and other child advocacy groups spend much of their time helping parents and children access the services they are entitled to under the law but do not receive without the assistance of legal advocates.[55]

In some cases, a lack of coordination results in missed opportunities. Many county departments are unsure how to leverage funding, particularly for transition-age children, who may qualify for assistance through numerous programs. Special education, CalWORKs, mental health, substance abuse, and family preservation funding can all be used to enhance services. Doing so requires significant collaboration and trust between the administrators of multiple local agencies and state programs. In many counties that trust has not been developed.

A Challenge of Coordination

Everett was removed from his mother's care because of her drug use. From the time he was an infant until he was 18½, Everett lived in multiple facilities and received multiple forms of treatment until he became too old to be served by the children's mental health system. Everett's history, as described by an Orange County probation official, reveals a system that failed to provide him an appropriate diagnosis and treatment plan for many years:

From the time he was an infant through age 12, Everett lived in a variety of foster homes before he was diagnosed with frontal lobe brain damage. By age 12 Everett was 5 feet, 10 inches tall and weighed 220 pounds. His aggressive behavior and difficulty with impulse control resulted in charges that sent him to the juvenile justice system. For the next five years Everett moved between various residential treatment programs before he was sent to a specialized, private facility in Texas at the age of 17. At 18½ Everett was discharged as an adult.

Everett, like many children before him and many since, was sent from one treatment program to another, from one public agency to another. Addressing the needs of children with needs like Everett's will require the multiple components of the service delivery system to recognize shared goals. No child should be placed in treatment without an accurate determination of his needs. All children should receive the right services the first time.

Parents, children and administrators point out that county agencies deny care to children stating that a separate agency is responsible for providing particular services or serving particular people. For instance, children with mental health and developmental disabilities can have difficulty accessing care because mental health programs and developmental programs each suggest the other is responsible for paying for that care.

Karen Hart, testifying on behalf of the United Advocates for Children, argued that families must become experts to navigate the system that makes it difficult for them to access the right services at the right time.[56]

Policy-makers say go while budget makers say stop

There are inherent tensions between the ambitions of policy-makers and the fiscal realities. But these tensions are often not reconciled directly – either in the formation of policies or the implementation of programs. Rather, these tensions are often unresolved, or pushed onto the street-level bureaucrats who must match complex regulations with the sophisticated needs of individuals.

A good example is the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program. Children enrolled in Medi-Cal are eligible for mental health screenings and treatment through EPSDT.[57] Yet just 5 percent of eligible children receive care.[58] Some counties serve more, others less. While this variation may be linked to the priority the counties place on serving children, it is clearly tied to how California administers the program.

In 1995 California was forced by a lawsuit to expand services through EPSDT. Under new rules, counties pay half of EPSDT costs up to a maintenance of effort (MOE) standard that is based on their pre-reform service rates. Children served above the MOE standard are funded with 100 percent state and federal dollars. As a result, it has been easier for counties with a low MOE requirement to expand EPSDT services than it is for counties with a high MOE requirement. The result is some counties have improved their "penetration rate" dramatically. Other counties have not.

Expanding EPSDT services also has been hindered by warnings from fiscal control agencies. The Department of Finance and the Legislative Analyst are concerned that EPSDT bills are rising. The Department of Mental Health has promised detailed scrutiny of billings. Together, these actions have signaled counties to be cautious about increasing EPSDT-funded services. So while EPSDT was conceived to provide comprehensive services to children enrolled in Medi-Cal, many do not receive services.

Similarly, AB 3632 promised mental health services to children in special education. But the State debated how to implement the program for several years while children waited for the services they were entitled to receive.[59]

Through EPSDT, AB 3632 and program regulations, counties receive mixed messages: legislation says a family will receive care, but complicated rules and policies prevent or slow access. Counties also have been held liable in the past when the State has told them to expand access to services, but then implements regulations that limit who can be served and how services are offered.[60] The safe path for counties is to limit access.

These administrative barriers limit access to care. Despite recent funding increases, children in California have needs beyond the capacity of existing treatment programs. Some of these children, like Everett, are sent to out-of-state programs. Others, like the 15-year-old girl in Sacramento County, end up in the juvenile justice system. Others end up on the streets, or cycling through inappropriate programs.

Expanding the level of funding for children's mental health will not alone ease the challenges for families seeking appropriate, compassionate care for their children.

Enrolling More Children in Medi-Cal

California has 1.85 million children without medical insurance. Two-thirds of them are eligible for Medi-Cal or Healthy Families, but are not enrolled. Among the barriers:

- ✓ Applications are confusing and complicated.
- ✓ Clients have unpleasant experiences with eligibility workers.
- ✓ Clients are not aware of the availability of coverage.
- ✓ Immigrants may be reluctant to apply on behalf of their children.

Sources: E. Richard Brown, Ninez Ponce and Thomas Rice. 2001. *The State of Health Insurance in California: Recent Trends, Future Prospects* . Los Angeles, CA: Center for Health Policy Research, University of California, Los Angeles. Page 32. Medi-Cal Policy Institute. *Speaking Out: What Beneficiaries Say* About the Medi-Cal Program. March 2000. Page 13. Medi-Cal Policy Institute. *Opening the Door: Improving the Healthy Families/Medi-Cal Application Process*. October 1998.

These children and their families are poorly served because counties do not have a continuum of services that is organized into a system that can provide support, treatment and responses for diverse needs.

As a Result, Many Needs Go Unmet

Inadequate mental health care has lead to higher juvenile justice costs and more children failing in school. Estimates suggest nearly all children in juvenile detention programs have mental health needs.[61] Many are sent to these programs because policy-makers have not developed and funded appropriate early intervention programs.[62] And research suggests that 80 percent of adolescent substance abusers have multiple mental health needs, with some evidence that mental disorders predate and contribute to their initial drug use.[63]

But without an appropriate continuum of care, disorders worsen and costs increase. Specifically,

Investing in Prevention

Prevention includes services that identify children at risk of needing care and helping them avoid those risks. It can mean preventing child abuse and childhood trauma that can make children susceptible to mental health needs or support a child to succeed in school to avoid the social and psychological stress and delinquency that can result from school failure.

California has a mixed history supporting prevention. From 1978 through 1992, the California Department of Mental Health had an Office of Prevention. The office closed because prevention was not a priority in a department focused on treating illness.

The mission of the office was to support prevention efforts in each county to reduce the number of people with mental health needs. Its accomplishments included:

- ✓ Recognizing exemplary prevention efforts with an awards program.
- ✓ Supporting self-help centers.
- ✓ Developing a media campaign on prevention.
- ✓ Linking university-based researchers with mental health leaders to understand effective approaches to prevention.

Source: Chuck Roppel and Nancy Mengebier, Office of Prevention, California Department of Mental Health.

Care is denied as needs arise. Children fail to access care for multiple reasons. Multiple eligibility criteria limit the children who can be served. Access criteria were established to limit government spending. Administrative directives, however, also can discourage eligible families from seeking help. As cited earlier, the California Mental Health Planning Council estimates that approximately 200,000 children need mental health care and qualify for public services, but do not receive the care they need.

The Los Angeles County Mental Health Department estimates that approximately 100,000 children in Los Angeles County schools need care, but are not enrolled in Medi-Cal or are not eligible for other programs. The county estimates that it has been able to serve just 10 percent of children from poor families who need services, but fail to qualify for mental health funding.[64]

Children's mental health staff in Orange County argue that more families could be served if the process for helping them were less cumbersome. They assert that "in the midst of crisis, families are turned away by discouraging and confusing financial procedures."[65]

Services are unavailable when and how children need them. Accessing the system does not mean that children receive the right package of services. Children can enter the children's service "system" through many doors – schools, mental health, probation, child protective services, child welfare, regional centers, and social services. They may enter through a door that can address some of their needs, but not all of them. For instance, children may be referred to mental health providers who can address their mental health concerns but who may be unprepared to address related substance abuse issues, learning difficulties, or the employment needs of the family.

State and county leaders have increasingly called for the integration of services to families with multiple needs. Children's System of Care, and other programs strive to provide care that recognizes the unique and holistic needs of individual children and families.[66] Counties have been able to coordinate and integrate care to a subset of the children, but have

been unable to extend integrated services to all the children who receive care. Generally, integrated care is reserved for children and families with the greatest and most expensive needs.

Costs are elevated. Counties administer upwards of 50 separate programs to meet the needs of children. Multiple county agencies administer multiple programs, some of which provide the same services to the same children. Each program has administrative costs that draw resources away from the actual care that can be provided.

Prevention opportunities are lost. Few resources are available for prevention and early intervention. There are no financial incentives for counties to spend a little now to save more later.

Families are frustrated and confused. For parents or children struggling to understand and address emerging mental health needs, which are often expressed through a child's behavior, it is unclear which programs or approaches are appropriate for them. Parents complain they must become experts to access the right services.[67] They don't know where to turn for assistance.[68] And they express concern that if they push their child into the wrong system, it can do more harm than good.[69]

Accountability is masked. Children "fall through the cracks" when no one entity is responsible for them. Many children end up bouncing from one program to the next as each determines that a child's needs are more closely aligned with some other program, rather than their own.

Three Forms of Prevention

Universal Prevention. Is intended to reach all community members with a general prevention message. It includes activities such as annual screenings, regular exercise and healthy eating.

Selective Prevention. Targets people with some risk of needing mental health services. Selective prevention programs include interventions designed to offer immediate services and support to prevent the escalation of needs. Activities include programs such as well-baby visits.

Indicated Prevention. Targets those persons with greatest risk for needing services. Indicated prevention generally includes treatment to address immediate needs while preventing re-occurring or long-term needs. Treatment to reduce high blood pressure to prevent heart attacks is an example.

	Universal	Selective	Indicated
Physical Health	Public messages supporting good nutrition, exercise and regular physical check-ups.	Childhood immunizations, well-baby visits, regular check-ups.	Visits to primary care physician to address minor illnesses before they escalate
Dental Health	Public messages supporting good nutrition, exercise and regular dental check-ups	Brushing and flossing daily, twice-yearly dental cleanings, braces.	Dental visits for fillings, crowns and other treatments to prevent loss of teeth.
Mental Health	Public messages supporting good nutrition, exercise and regular mental health check-ups.	Early intervention and support services for children struggling in school or at home.	Visits to mental health professionals to address mental health needs before they escalate.

Source: Joe Mahwinney, M.D., Washington State Department of Health.

Assessing the Costs of Unaddressed Childhood Mental Health Needs

Adequate mental health care will not prevent all children from failing in school, committing crimes, or needing hospitalization or long-term treatment. But mental health and related services can help children learn who otherwise would not. They can provide children the support they need to avoid criminal behavior. And they can prevent the escalation of needs and avoid the costs of long-term mental health services.

The following calculations, although imprecise, illustrate the potential savings and opportunities if access to mental health services were improved.

The Costs of School Failure. Less than 25 percent of children identified with emotional or behavioral disorders graduate from high school. In California 289,440 students dropped out of school from academic year 1995-96 to 1999-2000. On average an adult with no high school diploma earns $16,124 per year. In contrast, a high school graduate earns $22,895 per year. For students able to continue their studies, an undergraduate degree holder earns $26,235 per year.

The California Department of Education and the California Department of Mental Health have not researched the effect that inadequate mental health care has on the number of students who fail in school. But based on prevalence rates, if improved services could help just 10 percent of these students to earn a high school degree, their combined increased earnings would equal $195,979,824 for just one year.

Potential Impact: 289,440 students X 10%=28,944.
28,944 students X $6,771 in additional earnings = **$195,979,824**

The Costs of Juvenile Justice Involvement. Between 40 and 90 percent of the children in the juvenile justice system have one or more mental disorders. Some end up in this system simply because other services are not available. The 2000 average daily census in California's juvenile justice facilities was 11,529. The average length of stay was 27 days, with an average cost of $130 per day. If just 10 percent of the juvenile justice population was given treatment that prevented the need to enter this system, it would reduce costs by $4,047,030.

Potential Savings: 11, 529 children in justice facilities X 10%=1,153
1,153 children X $130/day X 27 days = **$4,047,030**

The California Youth Authority houses 7,300 youth per year at a cost of $37,000 each. Treatment costs add an additional $21,000. A 10 percent reduction in children going to CYA could reduce costs by $27,010,000 to $42,340,000.

Potential Savings: 7,300 youth X 10%=730
730 youth X $37,000/year (without treatment) = **$27,010,000**
730 youth X $58,000/year (with treatment) = **$42,340,000**

The Costs of Residential Treatment and Hospitalization. California licenses 13,481 residential treatment beds. It costs between $1,200 and $6,000 per month to serve a child in a residential program, depending on the level of services they receive. Three-fourths of the children served are in residential programs that cost between $4,858 and $6,000 per month. A 10 percent reduction in the need for residential treatment would save approximately $78,583,008.

Potential Savings: 13,481 youth X 10% = 1,348
1,348 youth X $4,858/month X 12 months = **$78,583,008**

The Metropolitan State Hospital Child and Adolescent program has the capacity to serve 120 children. State hospital care costs $120,000 per year. Reducing the need for hospitalization by 10 percent could save $1,440,000 per year.

Potential Savings: 120 youth X 10% = 12
12 youth X $120,000 = **$1,440,000**

Sources: California Department of Education. U.S. Departments of Commerce, Education and Labor, et al. *21st Century Skills for 21st Century Jobs*. 1999.; California Board of Corrections. 2000. *Juvenile Detention Profile Survey Report*. Gregorio Zermeno, Director, California Youth Authority. Testimony, October 28, 1999.; California Healthcare Association. California Department of Social Services. California Department of Mental Health.

No Clear Expectations to Guide Policy

It is difficult to identify the gaps in a continuum of care because the State lacks appropriate standards on the care and services that should be available. California has official standards that each county must meet in order to comply with funding regulations. However, some officials assert that existing standards are too low to be meaningful. They do not represent appropriate levels of care. In the absence of meaningful standards that can serve as goals or benchmarks, it is difficult to assess how well individual counties are doing. It is equally difficult to determine an appropriate level of funding for each county, or how additional resources could best be spent. Instead, the State and counties expand existing programs and pursue new funding without having assessed shortcomings or priorities.

For example, while it is certain that EPSDT costs are rising, policy-makers have no reliable source of information on how many children should be receiving EPSDT services and what those services would cost. It is unclear if EPSDT costs are rising too fast or too slow. Policy-makers do not know how many residential and hospital beds are needed.

More importantly, policy-makers are unable to calculate at what point the preventive care available through EPSDT will bring down long-term treatment costs because needs are identified and addressed before they escalate. And they cannot calculate the benefit of expanding preventive services to children and families who are not eligible for EPSDT.

Demystifying Children's Services

Some counties are working to explain the services available to children and families through parent guides and other information sources. Los Angeles County and Sacramento County, for instance, have developed resource guides in collaboration with parent groups.

Without standards that reflect our expectations for children needing prevention, residential, hospital care or other services, the development of an appropriate range of programs is not possible. For 10 years or more counties have struggled to develop an adequate supply of residential treatment programs. This challenge is no closer to being solved today than it was a decade ago. Although new funding has been made available through EPSDT and other programs, children are continually placed in residential treatment programs that cannot fully address their needs. Children, parents, teachers, service providers and others need standards that can guide their understanding of when residential and other programs are functioning appropriately and when they are not.

Problems are Clear, Solutions are Not

The challenges within the children's mental health system are generally well understood. Seasoned administrators can outline just how particular funding streams or management decisions lead to regrettable outcomes. But how to address these problems is less clear. The challenges are so significant and embedded in regulatory procedures and funding requirements that it is unclear where to start or what to do.

Hospitals and Residential Treatment

Children must be ensured access to appropriate hospital care and residential treatment services when and where they need it. Yet many counties cannot ensure that children will receive that care.

Psychiatric Hospitals The California Healthcare Association, nurses, parents and children argue that California has been unable to provide the right level of hospital care when and where it is necessary. Despite warnings of a shortage of inpatient hospital care for children and youth, state and local mental health officials have not acted to address this need. Some children are "dumped" into hospitals because others do not want to care for them. Others are abandoned in hospitals because counties have not worked to ensure appropriate residential placements are available when children are ready to leave hospital care. The crisis is significant. Children are being sent out of their home county, across the state and into hospital programs with no clear understanding of how long they will be there, where they will go when they leave or who is responsible for ensuring that the hospital care they receive is what they most need.

Some counties appear to be working with hospitals to address this issue. Others appear to have dismissed their responsibility to address this vital component of a continuum of care.

Residential Treatment. The Commission heard from probation officers, social workers and youth with experience in residential placements that children are often sent to facilities that do not have the capacity or the programming to address their needs. Children who require substance abuse services are sent to programs without those services. Children who need sex offender treatment are housed with children who are victims of sexual abuse. Many children who struggle in school are referred into programs that do not offer educational services, diminishing their chances of educational progress.

The barriers to improving residential placements are numerous. The State, counties and providers need to build the partnerships, trust and commitment necessary to address these barriers, including:

Liability. The State, counties and providers must ensure that providers are accountable for providing high-quality care without restricting the availability of services.

Facility Siting. Many neighborhoods are unwilling to accommodate mental health programs. The State, counties and providers must work together to ensure that siting barriers to do not prevent each community from meeting the needs of its children and families.

Sustainable Financing. The State, counties and providers need to work together to ensure that facilities are financed in a way that reduces costs while ensuring children have access to the care and support they need.

Regional Planning. Many communities will be unable to meet the specialized needs of the children they serve. The State, counties and providers should create a framework to establish regional approaches to ensuring the availability of specialized care when and where it is needed.

Each county has a responsibility to ensure appropriate and sufficient residential treatment is available to address the needs of the children in its communities.

Sources: California Healthcare Association and California Department of Social Services.

Health and Juvenile Justice

In this report, the Commission urges policy-makers to support efforts to help all children who have mental health issues that are compromising their development and education. A core group of children in California are burdened with the greatest troubles. Usually they are identified first as victims of violence, abuse or neglect – and then in some cases as perpetrators.

These children – often in foster care or juvenile justice facilities – place an enormous demand on limited public resources. They are often a threat to themselves, their families or the public at large. And problems that are not resolved in their childhood influence their actions as adults.

The prevalence of mental illness in the general population is roughly 10 percent. For children in the juvenile justice system, that rate jumps to 50 to 90 percent. Professionals who work with these children know they have emotional and behavioral problems that may or may not fit into formal definitions of illness. And there is significant evidence that with appropriate care and support – consistently and timely provided -- these children can better manage their behavior and address their emotional needs.

A legislatively mandated study calculated that providing mental health services to all children in juvenile justice and foster care programs would cost California an additional $100 million to $300 million. Unfortunately, the report does not estimate what it will cost communities, neighborhoods and the State if those services are not provided.

A more complete understanding of the choices and consequences would enable policy-makers to more thoughtfully resolve the perennial debate between fiscal analysts and advocates for children over how much to spend on public needs.

Fiscally sound decisions are not those that are premised on curtailing all public expenditures. Rather policy-makers seek to allocate resources based on a priority of needs and the potential for those expenditures to improve the public welfare. Elsewhere in this report the Commission argues the shortsightedness of rationing care with artificial eligibility distinctions limit public expenditures without considering the downstream consequences for individuals or public agencies. In the case of children under court-supervision, resources cannot rationally be allocated without factoring the long-term costs of not providing treatment.

Will those services enable them to complete school, free themselves from addictions, deal peaceably with conflict and reclaim their lives? The evidence is that treatment can improve outcomes, turning potential liabilities into reliable assets.

But current practice favors rationing care, and requires advocates and analysts to battle over every marginal increase in spending – as if public expenditures are not related across programs, over time and among individuals.

The Governor and the Legislature should not be satisfied with the analysis of mental health needs of children in trouble – not because of the estimated costs of providing services – but because policy-makers also need to understand the commitment they are locking themselves into in future years -- when problems unresolved among children mature into the violence and crime that cannot be ignored.

Many of these challenges will require reforms beyond mental health programs. The Commission outlines a strategy for truly developing a system for children and family services in Finding 5. But today, there is much that can be done to bolster mental health services. There are five elements to reforming California's mental health system:

1. Begin with a commitment. Reforming mental health care will require a commitment to ensure that every child and family receives the mental health services necessary to keep them healthy. That commitment must be followed by an assessment of community needs and resources. Reform will require establishing standards that will guide existing and new investments. And it will mean creating and maintaining the political and community push necessary to support children and families to be mentally healthy.

2. Assess needs. Counties must understand the needs of the children and families in their communities and their ability to respond. They should know who lives in their communities and the types of risks that make children vulnerable. They should document the availability of services, gaps in the continuum of care and develop strategies to fill those gaps.

3. Establish expectations and how best to meet them. Counties need to know how to best design programs to meet local needs. State and local agencies need to know what works and what has been proven

Improve Data Collection and Exploration

California has not used available data or developed new data to explore the quality of care. Mental health and related data should be explored to improve services. Among the questions to consider:

Child care. Can child care facilities provide a ready-made opportunity to assess needs and deliver preventive mental health care and related services?

Education. How are access to mental health services and school-readiness and/or school failure linked? Can improved access to mental health care improve student learning?

Child Welfare. What percentage of children in the foster care system access mental health services? Do high-quality mental health services reduce the need for placements, reduce costs and length of placement?

Physical Health. Is there a link between mental and physical health care costs? Can quality mental health care reduce the need for other health expenditures?

Juvenile Justice. Which children should be served through the juvenile justice system and which should be served through mental health? How many children with mental health needs end up in juvenile justice facilities because they have no place else to go? Can preventive mental health care produce long-term cost savings by reducing the use of juvenile justice facilities?

Workforce Development. What are the costs and benefits of providing mental health care to support parental employment? Should the parents of children with mental health needs have priority access to job training and employment programs?

ineffective in service delivery, funding design, accountability and oversight. Proven and promising practices could significantly improve mental health services in the following areas:

- ✓ ***Service delivery***. State and local officials need to understand how to build an efficient and effective service delivery system that prioritizes universal, selective and indicated prevention as well as acute and long-term treatment. Service delivery standards should include treatment protocols, case management, and collaboration across multiple public and private programs.

- ✓ ***Funding design***. State and local policy-makers and mental health leaders need guideposts to know which local agencies are adequately accessing existing mental health resources, which programs are underfunded and where to invest the next increment of funding.

- ✓ ***Innovation***. The promise of innovation needs to be continuously explored to improve the cost-effectiveness of mental health services. Tele-medicine and hiring mental health clients offer promise in addressing workforce shortages. Blended funding can enhance services by leveraging state and federal funding. Self-help centers for youth can provide low-cost support services. Community partnerships can build support for transition-age housing.

Building a Continuum that Reflects Healthy Child Development

Needs assessments and standards must reflect the range of issues affecting children from birth throughout their lives. Appropriate health and mental health care for mothers can ensure their babies develop into healthy children and then into healthy adults. Age appropriate care throughout a child's life can prevent the need for mental health and other services as they age.

Birth to age 5. Young children present the greatest opportunity to respond early to risks and prevent the need for services. Each county should ensure that primary care physicians, pediatricians and child care professionals know how to recognize potential mental health needs, know how to refer parents into services that will respond, and avoid stigmatizing the family. No child should be expelled from a child care program without first being assessed for mental health needs. Counties need to develop the programs necessary to support these goals.

Ages 5 to 18. Most children will enter school at age five. Teachers, administrators, counselors and others in schools should be able to identify potential needs and promote preventive mental health services. All children struggling in school should have access to care that can enhance their learning.

Ages 18 to 25. Mental health needs do not stop when a child turns 18. This transition age is often the most stressful period in a person's life as new responsibilities and challenges are addressed. Transition-age children face unique risks and may be harder to serve because they often are not participating in centralized programs like schools. Access to housing, vocational education and job training become particularly important to transition age youth. Counties should explore the resources available and develop strategies to ensure that appropriate care is available until a person is able to function independently or transition into a robust adult mental health system.

Children, Learning and Mental Health

California makes an enormous investment to foster the ability of children to learn, to strengthen their problem-solving skills, and to rouse a curiosity that leads to life-long learning. The learning process starts with the family, may involve child care providers, and generally includes many staff in public or private schools. School and community partnerships to address mental health concerns and promote social and emotional development are essential in helping to realize the benefits of this investment.

Factors that lead to behavioral and emotional problems contribute to problems at school. In some instances, young children are expelled from child care settings because of difficult-to-handle behavior or developmental delays. School-aged children may do poorly because staff do not recognize that problems such as poor concentration or frequent absences may stem from factors related to mental health and related concerns.

Increasingly teachers are seeking to better meet the needs of struggling children. They recognize that school support staff and community mental health providers can help them address barriers to learning and promote healthy social and emotional development. Yet, essential school-community partnerships for mental health do not happen without initiative.

School-community partnerships for mental health help professionals recognize mental health needs in children, enabling them to make sensitive and culturally appropriate referrals, and facilitate appropriate responses to learning and development hurdles. Many efforts around California and the nation can be used as models of school-community partnerships.

Child Care. Early childhood educators recognize that the field of mental health can help them understand the learning and development barriers children face in their early years. California has several initiatives in place to train child care providers to recognize unaddressed mental health needs in young children and to make appropriate referrals to mental health services that can help. One program in particular, the Early Childhood Professional Staff Development Project within the Vallejo Unified School District, supports teachers and supervisors working with children as young as 3 months who have challenging behaviors. The programs help teachers and children to understand the sources of difficult behavior and to build positive relationships with even the most difficult children to improve their learning. And through the work of local Proposition 10 commissions, many counties are exploring the inclusion of a mental health focus in efforts to promote school-readiness for young children.

K-12 Schools School-based mental health partnerships are being built. In Los Angeles County the Department of Mental Health is working with local school districts and other agencies and is co-sponsoring a major conference to strengthen collaboration for mental health in the schools (November, 2001). The intent is to recruit new partners to improve school-based programs and services for children. Other examples are in a resource developed by the Policy Leadership Cadre for Mental Health in Schools, which charts the course for building school-mental health partnerships.

The lesson of these partnerships is that new categorical funding for school-based or child care-based mental health services would be the wrong approach. A categorical program would inevitably ration care in a few schools. A more robust solution would promote local partnerships that tap all available resources to meet local needs for as many children as possible.

Sources: Policy Leadership Cadre for Mental Health in Schools. 2001. "Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations." Los Angeles, CA: UCLA Department of Psychology.; County of Los Angeles Department of Mental Health. 2001. Letter to the Little Hoover Commission. On file.; Child Development Policy Advisory Committee.

- ✓ ***Data exploration***. State and local agencies collect and maintain data on a range of service needs and programs. But often those data are reported in ways that are meaningless. Having reams of data does not ensure the information is appropriate for answering simple questions. Policy-makers and program administrators could improve policy, resource allocation decisions, and programs by using information to understand who is served, how well they are served and how to improve services.

- ✓ ***Accountability and oversight***. Policy-makers and mental health leaders need standards and performance information to let them know when their mental health programs are adequately serving or failing to serve children and families in need, and at what cost.

California Mental Health Advocacy Commission

In November 2000, the Little Hoover Commission said the Governor and the Legislature should ensure that no one who needs care is denied access to high-quality, tailored mental health services. The first step is to establish a California Mental Health Advocacy Commission to serve as a catalyst for change, set expectations and establish responsibility for mental health services. Specifically, the Commission should:

- ✓ Be of limited term and funded from public and private sources.
- ✓ Develop strategies to overcome stigma.
- ✓ Detail need.
- ✓ Assess costs of failure.
- ✓ Provide for on-going policy advice.

Expectations and standards in these areas are necessary to understand how particular issues impact the availability and quality of care, and to craft informed strategies to make improvements.

4. Success requires pressure from the bottom and the top. Change will occur when pressure from the bottom and accountability from the top work toward common goals. In its November 2000 report the Little Hoover Commission recommended the creation of the California Mental Health Advocacy Commission to calculate the costs of failed mental health policy and advocate for reform in the private and public sectors, in communities and at the statewide level.

Advocacy is especially needed at the local level. Local policy-makers need to understand how their decisions affect the quality of care and how state and federal policies prevent the success of local programs. Local policy-makers need a foundation upon which to advocate for state and federal reform so that they can be successful in serving children. Without a strong local voice, mental health reforms will falter.

5. Success requires reinvestment in prevention. If California had a continuum of care it would be driven by prevention. The State does not have that continuum. In fact, some criticize California's approach to mental health care saying there is no "health" in mental health. The State instead has a program focused on mental illness. Critics assert

California has a reactive, crisis driven system that rations care only to the most significantly ill. A reinvestment in prevention is necessary to change the direction of mental health policies to ensure they promote health, rather than treat illness.

California cannot afford to provide mental health services to all who need care unless policy-makers and state and local mental health leaders dedicate themselves to prevention. There may be enough resources to serve all who need care if those services are delivered effectively. There will not be enough resources they are not.

Recommendation 1: The Governor and the Legislature should establish a commitment that all children with mental health needs shall be eligible for and receive high-quality, efficient mental health and related services. Legislation should:

- ***Require each county to establish a Child and Family Services Board***. The role of the board could be assumed by an existing entity. The board in each county should:
  - ✓ ***Assess needs***. Each county should understand how many children are at risk for needing services, how many require care and what types of services they need.
  - ✓ ***Document available services.*** Each county should clearly document the availability of mental health and related services in its communities.
  - ✓ ***Define gaps in needed care***. Each county should compare needs with services to determine deficiencies in the availability of services in its communities.
  - ✓ ***Develop a strategy to address those gaps.*** Each county should develop a strategy to address unmet needs.
  - ✓ ***Develop mechanisms to locally report on needs, gaps and progress toward meeting those needs.*** Each county should clearly and periodically report on local needs, gaps in the continuum of care and current efforts to address those gaps.
- ***Establish an Office of Prevention within the Department of Mental Health***. The Office of Prevention should be charged with identifying prevention opportunities and advocating for prevention, including documenting the costs and benefits of prevention strategies in mental health and related fields.
- ***Plan for private-public universal coverage.*** The Department of Mental Health, with support from the Legislative Analyst's Office and the Department of Finance should:

- ✓ ***Identify coverage goals.*** The department should determine what percentage of the population should have private sector mental health insurance coverage and what percentage should be served through public sector programs.
- ✓ ***Calculate the cost.*** The department should document the costs of providing public sector coverage to the target population.
- ✓ ***Develop a strategy***. The department should outline the steps to offering 100 percent needed services to the target population and participate in the task force on private sector mental health coverage outlined in Recommendation 2.

❑ ***Establish a Human Service Research Center.*** The center should be a partnership between the California Department of Mental Health, local mental health agencies, public and private universities and others. It should be charged with the following tasks:

- ✓ ***Develop clear standards to guide policy.*** The center should establish clear standards that will guide expectations for the delivery of mental health and related services. Standards should be formulated that indicate the goals to be realized with public programs.
- ✓ ***Develop an information clearinghouse.*** The center should document and disseminate information on the latest available knowledge on proven, promising and disproven service delivery approaches, treatment protocols and other issues relevant to the human service delivery system.
- ✓ ***Identify incentives.*** The center should encourage the adoption of proven and promising approaches to service delivery. It should develop strategies that encourage local agencies and professionals to continuously upgrade skills, treatment approaches and other practices that will improve outcomes for children and families.
- ✓ ***Serve as a research and data pipeline.*** The center should serve as a single point of access to state data. It should develop streamlined policies for human subject reviews and other necessary research protocols. It should develop research agendas relevant to policy-making and the delivery of services, and support grant writing and other efforts that improve awareness, dissemination and adoption of proven and promising practices. The center should guide and advise state efforts to evaluate social service programs.
- ✓ ***Provide public access to performance data.*** The center should develop a publicly accessible information source, such as a Web site, that presents county and statewide data on policy goals, benchmarks, service availability, funding and outcomes.

Building a Foundation for Reform: First Steps

- ✓ The Department of Mental Health, in conjunction with other state departments, should determine what percentage of the population should be expected to receive mental health care from the public sector.
- ✓ Counties should form or designate a child and family board to determine broad community needs, assess gaps in services and outline a strategy for addressing them.
- ✓ The Department of Mental Health should develop a budget change proposal to create an Office of Prevention.
- ✓ The Legislature should direct the Department of Mental Health to solicit proposals for the development of a Human Services Research Center.

Provide Appropriate Resources

Finding 2: Mental health funding fails to promote quality, efficient care.

Children with mental health needs are served through a variety of public programs intended to keep them safe, healthy, at home, and to help them learn and recover. While some children receive world-class services, others are poorly served, ignored completely, or occasionally even harmed. The quality of care – whether children are helped or ignored – is partly a product of how programs are funded.[70]

The chances that children will receive appropriate and quality care also depend on where they live and how they are defined by government programs: Do they live in a county that makes use of available funding, or not? Are they abused or are they abusers? Are they considered mentally ill or developmentally disabled?

Children do not receive care based on need alone. Rather, services follow eligibility criteria. Establishing eligibility can be a complicated issue because of the variety and complexity of public programs and their funding sources. This complexity drives up costs and drives down quality. It frustrates children and parents. And it makes it nearly impossible to improve the quality of care.

Despite Significant Funding

California spends some $2 billion a year on services provided by public mental health programs.[71] Less than half of that is estimated to be spent on children. But children also can receive mental heath care through schools, child welfare programs, regional centers for the developmentally disabled, probation departments, child care programs, even workforce development efforts such as CalWORKs. The multiplicity of programs makes it difficult to calculate how much is spent on children's mental health needs.

Generally, mental health services are funded through several core sources:

- ***Medi-Cal/EPSDT.*** Mental health services are available to low-income Californians who qualify for Medi-Cal through county mental health

Children's Mental Health Funding

Two primary sources of funding offer some children an entitlement to mental health care. Medi-Cal is designed to ensure that all enrolled children receive a range of preventive, intervention and treatment services. Many children who could be served are not enrolled, however, so Medi-Cal is not available to all who could benefit.

AB 3632 entitles children in special education programs to mental health services. The process for establishing eligibility complicates the ability of many children to access AB 3632 services. Thus many children who would be eligible for care do not receive services.

programs. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program within Medi-Cal entitles children to a range of services. California spent about $440 million through Medi-Cal and EPSDT mental health funding for children in fiscal year 1999-2000.[72]

- ***Realignment***. The State also dedicates funds directly to counties for a variety of social and medical services, including services to seriously emotionally disturbed children. In fiscal year 1997-98, counties spent approximately $884 million through realignment on mental health services to children and adults.[73] The California Department of Mental Health does not track how much of that funding was dedicated to children, although estimates suggest that less than half was spent on children's services.
- ***Children's System of Care***. Children with a serious emotional disturbance may be able to access care through Children's System of Care, which is a multidisciplinary, multi-agency approach to serving children. California provided about $41 million to 54 counties to support these programs in 2000-01.[74]
- ***Individuals with Disabilities Education Act (IDEA/AB 3632).*** Children and young adults under the age of 23 are eligible for special education services if they have one of 13 disabilities, including an emotional disturbance.[75] In 1984, legislation clarified that county mental health agencies are responsible for providing mental health services, including residential services to children in special education when necessary. In fiscal year 2000-01, local agencies spent some $47 million for IDEA services.[76]

Additional funding is available through specialized programs or statutory provisions that allow counties to blend funding from non-mental health sources. These programs include:

- ***Early Mental Health Initiative (EMHI)***. Children in kindergarten through third-grade can receive prevention and intervention services through local education agencies. In 2000-01, EMHI provided $15 million to fund services at 581 school sites in 38 counties throughout California.[77]
- ***Wraparound Services Pilot Project (SB 163).*** The wraparound pilot project is a five-year project (1998-2003) that allows counties to use state foster care funds to provide intensive services that would

allow children to remain at home and avoid placement in a residential facility. The project does not provide additional funds. [78]

- ***Youth Pilot Project***. The Youth Pilot Project gave six counties flexibility in how they use state and local human service funding to provide integrated, efficient care to children. The Youth Pilot Project did not provide additional funding. [79]
- ***SB 933***. SB 933 allows counties to create performance agreements with private providers and permits them greater flexibility in spending foster care funding to support those agreements. [80]

Counties potentially have access to numerous other funding sources. Children with mental health needs may also be served through their primary health care provider, through a foster care placement, child protective services or other public programs. Other funding sources also may be available. Appendix C identifies a range of funding sources that can be made available.

Funding Sources are not Aligned with Needs

Despite multiple funding sources, many children fail to receive the care they need, when they need it. Some children are ineligible for care. Others are eligible, but have difficulty accessing appropriate services. Still others are served by one public agency that is skilled at addressing one set of needs, but inexperienced in others. Equally important, funding streams can discourage local agencies from offering care, investing in prevention or pursuing multidisciplinary approaches that would better serve children and their families. As a result, programs are sometimes ineffective, inefficient and inequitable.

One Result is Ineffectiveness

Funding for mental health and related services does not promote effective services. When eligibility criteria restrict access to services, a child's needs often become severe and expensive to address. Categorical programs that thwart holistic care limit the benefits of the services that are provided. And diffused resources blur accountability for addressing multiple needs or for outcomes. As a result, some children are unserved and others are underserved. Consider the case of D. K., a 15-year-old boy with a history of mental disorders. [81]

D. K. suffered serious emotional and physical abuse. He has been in six placements in the last seven years.

Both parents had substance abuse problems. D. K. suffered serious emotional and physical abuse. He was placed in a group home at age 8 for assaulting someone. He has been in six placements in the last seven

years. At age nine he was arrested for burglary. He has been arrested and incarcerated in juvenile hall eight times in six years. He has been hospitalized four times for self-injurious, suicidal behavior. He has multiple mental health and developmental diagnoses. He functions four grades below his age group in all subjects.

Although it is clear that D. K. has significant mental health and educational needs, county probation staff have limited resources to serve him. Juvenile halls are not primary mental health facilities and is less equipped than local schools to meet his educational needs. Still, D. K. has sat in juvenile hall because no other public agency has been able or willing to address his needs.

In its November 2000 report, the Little Hoover Commission argued that eligibility criteria forces counties to negotiate treatment plans for adults based on the services they are eligible to receive rather than their needs. Children also receive negotiated services, denying them care important to their recovery. While most children in out-of-home placements need mental health services, there are no mechanisms to ensure these children receive screenings and treatment.

Santa Cruz County, which has integrated mental health and probation services through its Children's System of Care, estimates that 200 children should participate in the program. But just 62.5 percent of the target population receive the integrated services the program offers.[82] Limited funding is one barrier to reaching more children.

In Sacramento County the probation department has built an impressive assessment program for children with mental health or related needs. The assessment identifies a child's needs in 10 separate life areas, including: criminality, substance abuse, mental health, physical health, family, education, social attachment, occupational and recreational needs.[83] But the Sacramento County Mental Health Department and local educational agencies are not involved in those assessments. And many children do not receive the care they need because the probation department is not fully equipped to address the needs it identifies.

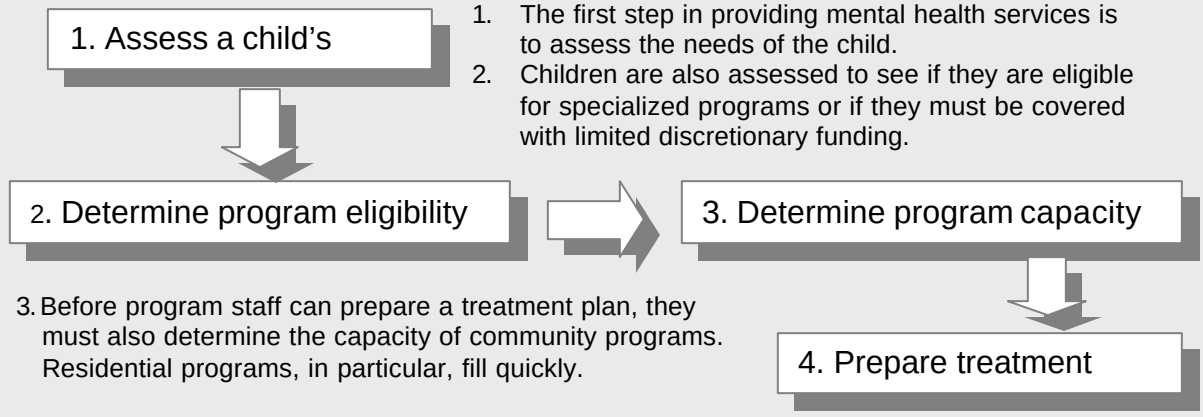
Or consider a case for a northern county woman with young children in the care of her county mental health program. Her children were sent to foster care while she addressed her mental health and substance abuse needs. After receiving therapy and drug treatment, the mother petitioned the court for the return of her children. Child protective services opposed the reunification because the mother had been evicted from her apartment and could not obtain affordable housing in her rapidly growing area. While considerable resources had been spent treating this woman and caring for her children, none of the participating public

agencies could help the family address the barrier that prevented them from being reunited – affordable housing.

Each of these examples demonstrate that despite significant funding counties are often unable to provide the care children and families need. The following box describes the complex path families must navigate.

Negotiating Mental Health Treatment

Local mental health agencies have access to some 19 major local, state, federal and private funding sources. While there are limitations on how most funds can be spent, some allow greater discretion.



1. The first step in providing mental health services is to assess the needs of the child.
2. Children are also assessed to see if they are eligible for specialized programs or if they must be covered with limited discretionary funding.
3. Before program staff can prepare a treatment plan, they must also determine the capacity of community programs. Residential programs, in particular, fill quickly.
4. Treatment plans therefore are based on a negotiation between a child's needs, program eligibility and available space. Because of these limitations, providers are often unable to tailor services or provide the most effective and efficient care.

Another Result is Inefficiency

Inefficiency results when programs are unable or discouraged from promoting prevention, providing consistent care or fully utilizing available funding. Costs increase when programs focus on short-term problems instead of managing for long-term outcomes. There is no fiscal incentive in mental health or related programs to ensure that children and families receive continuous, high-quality care. Existing funding rules and regulations lead to inefficient services in the following ways:

Opportunities for prevention are missed. As stated in Finding 1, mental health funding is often unavailable for prevention. Funding rules and limited service capacity create pressure to respond to crises and acute needs, which restrict opportunities to focus on prevention and early intervention.

Care is not consistent. Costs escalate when programs fail to leverage or recognize the investments of other public agencies. There is no continuity of care as children move between programs. Health records

often are lost, meaning children receive new immunizations, new treatments and must see new doctors. School records often are lost, as well, requiring classes to be repeated, and increasing the chances the child will drop out.[84]

For example, the majority of children at Metropolitan State Hospital are sent from Los Angeles County. Hospital staff report that children arrive without treatment histories. Each child receives a new assessment and new treatment plan independent of the services provided elsewhere. The clinical staff and the children at Metropolitan are frustrated because it can take many weeks to determine the most efficient treatment approach for a mentally ill child. Duplicate assessments and multiple refinements to a treatment plan raise costs and the suffering and anguish children experience.[85]

Funding programs are complex. Funding complexity is another cause of inefficiency. The complexity of rules and regulations make it difficult for families to navigate services. They are not sure where to turn for help or how to navigate the system.[86] This uncertainty delays access to the right care at the right time. Under CalWORKs, for example, families enrolled in Medi-Cal who transition into employment are eligible for coverage. Yet many families lose coverage because they are unaware they can maintain their benefits.[87]

Funding is not focused on quality. Mental health funding is distributed based on how many are served, not how well they are served. For instance, Medi-Cal funding reimburses counties for units of service.

Focus on Immediate Needs Increases Long-Term Costs

Linda has a serious mental illness and has been in the public service "system" in her county since she was just four. She is turning 18. She is incapable of caring for herself and officials in her county have no plan for addressing her long-term needs. Consider her experiences, as described in her treatment history:

> *By age four Linda was the victim of horrific and extensive neglect and abuse. She is mentally ill and has never been taught to control the assaultive and compulsive behavior associated with her mental illness. She has cycled through multiple foster care placements, community hospitals, juvenile halls and the state mental hospital. During her 14 years in care her diagnoses have varied and she has been prescribed just about every medication available to psychiatry. She has not received the consistent, supportive and loving care that could have enabled her to function as an adult.*

During 2000 and 2001, Linda has cycled between state and community hospitals and county juvenile halls because no state or local agency is willing or able to address her needs. She is pushed from one program to the next because she is deemed too expensive. Some evidence suggests that children like Linda may end up in the juvenile justice system, where their needs are often not taken seriously, as a way to manage their behavior rather than address their needs.

In Orange County, mental health providers say they are rewarded for the number of clients seen, not the quality of care provided. They are pushed to get more children in and out because more clients mean more billing, even though short-term efficiency may increase long-term liability.[88] Lower quality care results in prolonged need for services and higher costs.

Funding is not focused on families. Some parents have been forced to relinquish custody of their children to become eligible for care through the foster care system, an egregious example of inefficiency.[89] By relinquishing custody, care can be arranged that otherwise would be more difficult to obtain or would require counties to spend locally controlled dollars.

Funding encourages short-term cost management. Finally, the present funding structure is inefficient because it fails to ensure that service providers do their best to meet short-term needs and avoid long-term costs. Consider the case of D.K. above. He received services for seven of his 15 years and his needs continued to grow. His education was suffering. He was placed in residential programs that failed to address his needs. And as he becomes increasingly aggressive he runs the risk of long-term involvement with the juvenile and criminal justice systems. Or consider the case of Linda that follows. She was taken into foster care at 4 years old. Because her needs were not addressed when she was a toddler, her need for public services has grown as she has grown and will continue into her adulthood.

Linda's psychiatrist argues that proper intervention and treatment when Linda was a toddler could have taught her to control her behavior and halted the progression of her illness. But she did not receive that care and is likely to require life-long support.

In addition to the moral consequences of failing to address the needs of a child who has been in public custody since she was four-years-old, there are financial consequences. Long-term care, repeat hospitalizations, publicly supported housing and other services will cost the public sector much more than it would have cost to provide Linda with the comprehensive treatment that would have helped her recover when she was a very young child.

Funding for mental health care in California is inefficient because it does not ensure that children, particularly children like Linda, receive targeted, comprehensive care that will reduce the need for long-term services.

The California Department of Mental Health does not know how many children receive care when they are very young and continue to need services as they age because the initial response to their needs was inadequate. Yet mental health experts are persuasive that high-quality prevention and early intervention services can help children overcome the challenges they face to develop into healthy, happy, self-reliant adults.

One administrator at the California Department of Mental Health expressed her frustration with the incentives and disincentives in mental health funding by saying, "The department is not in the business of helping children. We are here to monitor how money is spent."

Third Result is Inequity

The present funding structure results in two forms of inequity. First, the quality and availability of care varies by county. Families complain that the most reliable way to improve the quality of care available to their children is to move into a county that has better public mental health services. Second, how a child's needs are defined can determine if the child is eligible for care. For example, some children are diagnosed with conditions that do not appear on the approved list of treatable conditions and are not served. Other children are diagnosed with needs that make them eligible for limited services over a limited period of time. And still others are diagnosed with needs that make them eligible for life-long care regardless of their needs.

There are two primary sources of inequity in funding:

Funding is not allocated to counties based on need. Approximately $400 million is allocated from the General Fund to counties through grant and pilot programs.[90] One characteristic of those programs is that they are not available to all counties.

Most grant programs require counties to compete for limited funds. County administrators argue that competitive grant programs favor larger counties with staff who can be dedicated to developing grant proposals. They suggest that smaller counties compete less effectively.

The table on the following page presents total per capita mental health spending by county. The table demonstrates wide variation in per capita spending on mental health. While some of that variation can be attributed to local decision-making, much of the variation is tied to how the State distributes funding. Pilot and grant programs in particular have contributed to the ability of some counties to dramatically increase available mental health resources in ways unavailable to other counties.

Clients argue that funding inequities across county lines result in dramatic differences in the quality of care. The Commission heard emotional testimony from parents who were forced to move to different counties to ensure their children received appropriate services.

Eligibility is driven by diagnosis. Inequities also result when funding creates disparities in the quality of care based on the diagnosis a child

receives. State and federal funding rules stipulate that children with a select list of diagnoses can be served. Children with other needs often cannot be served. Each funding source has rules that govern what services are covered and the needs that can be addressed. In general, children must be diagnosed with a serious disorder before they can receive services.

Parents can be frustrated when their child's needs are defined in a way that makes them illegible for care. For instance, Sacramento County has two families that live in an upscale neighborhood, each with a teenage

Per Capita Mental Health Spending

Experts generally agree that about one out of five persons will experience a mental health need at some time each year. The prevalence of mental health needs varies based on age, race/ethnicity, gender, socio-economic status and other variables. In general however, the likelihood that people will need mental health care is fairly consistent across the population.

One illustration of the inequity in the accessibility of mental health services is the per capita funding available through each county. The data below reflect 1998-99 mental health spending as reported by the California Department of Mental Health and the July 1, 1999 population of each county as reported by the Department of Finance. California has wide variation in per capita spending on mental health across counties, from a low of $47.58 in San Mateo to a high of $240.91 in San Francisco.

COUNTY	1999 Population	1998-99 Mental Health Funding	Per Capita Spending	COUNTY	1999 Population	1998-99 Mental Health Spending	Per Capita Spending
Los Angeles	9,570,000	$753,649,922	$78.75	**El Dorado**	156,100	$9,211,640	$59.01
Orange	2,842,400	$167,934,987	$59.08	**Imperial**	144,100	$11,413,534	$79.21
San Diego	2,814,500	$176,193,829	$62.60	**Sutter-Yuba**	140,200	$11,405,753	$81.35
San Bernardino	1,711,300	$114,259,567	$66.77	**Kings**	129,800	$8,477,900	$65.32
Santa Clara	1,688,100	$144,643,688	$85.68	**Humboldt**	127,100	$16,645,218	$130.96
Riverside	1,538,100	$114,999,395	$74.77	**Napa**	124,300	$14,663,741	$117.97
Alameda	1,443,800	$180,428,078	$124.97	**Madera**	123,800	$8,813,920	$71.19
Sacramento	1,219,500	$106,814,519	$87.59	**Nevada**	91,600	$6,045,184	$66.00
Contra Costa	948,700	$89,585,375	$94.43	**Mendocino**	86,800	$9,512,911	$109.60
Fresno	804,200	$77,311,357	$96.13	**Lake**	58,200	$5,214,463	$89.60
San Francisco	776,300	$187,021,456	$240.91	**Tehama**	56,200	$5,714,132	$101.67
Ventura	753,600	$52,616,196	$69.82	**Tuolumne**	54,500	$3,844,745	$70.55
San Mateo	709,800	$33,770,487	$47.58	**San Benito**	53,100	$2,705,442	$50.95
Kern	664,100	$59,519,030	$89.62	**Siskiyou**	44,750	$5,466,719	$122.16
San Joaquin	563,100	$47,210,491	$83.84	**Calaveras**	40,850	$2,311,824	$56.59
Sonoma	458,700	$34,685,673	$75.62	**Amador**	35,050	$1,709,023	$48.76
Stanislaus	447,400	$48,600,107	$108.63	**Lassen**	34,050	$2,521,186	$74.04
Monterey	401,700	$26,198,294	$65.22	**Del Norte**	27,850	$3,909,823	$140.39
Santa Barbara	400,900	$40,744,603	$101.63	**Glenn**	26,700	$2,900,385	$108.63
Solano	393,500	$30,233,484	$76.83	**Plumas**	21,000	$2,076,867	$98.90
Tulare	371,200	$33,363,801	$89.88	**Colusa**	18,950	$1,858,144	$98.06
Santa Cruz	256,600	$29,870,204	$116.41	**Inyo**	18,300	$2,187,138	$119.52
Marin	247,300	$29,368,993	$118.76	**Mariposa**	17,100	$1,772,300	$103.64
San Luis Obispo	246,400	$16,514,561	$67.02	**Trinity**	13,200	$1,940,885	$147.04
Placer	245,500	$13,035,140	$53.10	**Mono**	12,750	$927,125	$72.72
Merced	211,300	$17,530,146	$82.96	**Modoc**	9,550	$1,323,961	$138.63
Butte	203,800	$23,814,728	$116.85	**Sierra**	3,550	$567,289	$159.80
Yolo	167,600	$15,382,427	$91.78	**Alpine**	1,190	$253,351	$212.90
Shasta	163,600	$15,603,804	$95.38				

Inequity means two families that have the same needs are unable to access the same services.

child who has a disability. In one family, the child has a developmental disability. In the other family, the child has a mental disorder. The first family is eligible for comprehensive public services for the child from her birth until she dies. The second family is ineligible for public services. In reality, the first family is able to manage with limited support. The second is struggling. The son has been suicidal and the family needs support, yet that support is not available to this family through public programs. Inequity means two families that have the same needs are unable to access the same services.

This example is repeated every day for children entering juvenile detention facilities. Because federal rules prohibit counties from using Medi-Cal to fund services in detention facilities, counties must find alternative funds to provide these children the care they need.[91] Without a dedicated funding source, many counties decide not to provide these services. While in custody those children do not have access to the same level of mental health care as they would if they were in a mental health program because of their needs, rather than a detention facility because of their behavior.[92]

Access to care can also be determined by how old a child is at the time of a diagnosis and the cause of their needs. For instance, children diagnosed with neurological disorders who are diagnosed prior to age 18 are eligible to receive lifetime services through California's Regional Centers. In contrast, people who sustain neurological injuries after age 18, despite having the same needs and disabilities, are not eligible for Regional Center services.[93] They may, however, be eligible for less comprehensive care provided through the mental health system.

Increasing Access to Care

In past years policy debates over inadequate mental health coverage have focused on increasing the level of mental health services available through public programs and expanding eligibility criteria to include more people or cover more services. More recently California and the federal government have pushed for increased private sector insurance coverage for mental health care.

New state and federal parity laws require private insurance policies to offer mental health coverage that is in line with the benefits available to people with physical health needs. Parity laws are intended to improve the quality and availability of mental health care through the private sector.[94]

There is some hope that private sector insurance coverage for mental health needs may reinvigorate the push for greater investment in prevention. Mental health programs may become more efficient if the private sector fully endorses the spirit of parity legislation. Although private sector mental health coverage is not new, parity laws are not fully tested and their impact on the ability of people to access care is poorly understood. It will be some time before research will conclusively document the adequacy of parity legislation as a strategy for increasing private sector coverage. Parity efforts have revealed that California has not adequately leveraged the ability of the private sector to provide mental health coverage.

Without robust private sector insurance coverage for mental health needs, public mental health funding is spread too thin. Public sector mental health care should be a safety net for people who cannot afford private sector mental health care. Building a stable, reliable and adequate mental health safety net with public resources would be easier and more efficient if greater numbers of Californians could rely on private sector coverage. Parity is a start, but just a start.

Categorical and Grant Funding Create Barriers

Categorical and grant-funded programs can improve access to care, but can also create new barriers to providing efficient services. The rules, procedures and reporting requirements of categorical programs that are designed to ensure that ineligible clients do not receive care, can increase administrative overhead, limit opportunities for efficient prevention and deny care to some children who need services. This approach to funding:

Creates High Administrative Costs. New programs almost always mean new applications, reporting requirements and audit trails. Added administrative costs limit their efficiency and often their utility. Increasingly, counties are questioning the value of new programs because of the new costs involved. Several counties do not receive SAMHSA funding because the dollar amounts are too small to justify the staff time and resources necessary to comply with administrative requirements. Three counties that would be eligible for $250,000 or $725,000 through the Children's System of Care do not participate partially because of added costs, reporting and infrastructure requirements.

Is Not Always Available Where Needed. Most grants are allocated on a competitive basis to ensure that limited resources are used in the most efficient and effective manner. However, some local agencies are better able to compete for grant funding. The result is that wealthier, often larger counties obtain more grants while smaller, poorer counties obtain fewer. Competitive grant programs do not necessarily ensure that limited resources are directed to the areas of the state with the greatest needs.

Encourages Staff Turnover. Grant funding also can result in higher costs as counties must recruit and hire new staff for each new grant program. The temporary nature of grant funding results in high staff turnover when there are gaps between the expiration of an older grant and the start of a new grant.

Creates Impenetrable Bureaucracies. A fundamental challenge of categorical funding for children's services is the complexity of service delivery systems built around multiple categorical programs. The federal government has over 500 categorical programs for children. California's counties have over 45 sources of funding for children (See Appendix C). Complexity limits the ability of policy-makers, administrators and the public to understand how services for children are funded, what services are available, how efficiently and effectively resources are being spent, and whether they are adequate.

Goals for Mental Health Funding

Mental health funding should motivate good outcomes. It should encourage counties to pursue the most effective, efficient strategies for providing care. Funding should create incentives for counties to invest in programs and approaches that have shown results and reduce the use of techniques that have been demonstrated to be ineffective. It should encourage local agencies to document their results and consistently explore how to improve outcomes. And it should encourage local agencies to seek out children and families in need of services and ensure that they receive necessary care before their needs escalate. The Commission has recommended that California reform mental health funding in the following ways:

Create a stable, flexible funding base. The majority of mental health resources should be stable, provide incentives that promote efficiency and effectiveness, and give local agencies discretion to tailor programs to meet individual needs.

Provide incentives to do better. The State should provide incentive funding to motivate local authorities to adopt practices proven to enhance services and outcomes.

Metropolitan State Hospital: How Pricing Could Improve Care

Metropolitan State Hospital has the capacity to serve just 120 children at a time. At $120,000 per year, the hospital should only be providing care to children who have significant needs and no other place to serve them.

Hospital staff and the children are frustrated with how the hospital is administered. Children arrive with incomplete treatment histories and school records. Some of the children who are sent to the hospital have needs that cannot be met by the program.

Staff are concerned that when children arrive without appropriate records, the most effective treatment programs are delayed, additional and unnecessary resources are spent on repeat assessments and multiple meetings to adjust their treatment. Also, schooling is delayed as a child's educational needs must be reassessed. Many children reported they lose credits, are forced to repeat classes and ultimately fail to graduate because no one kept track of their attendance as they moved from one treatment program to another, and from one school to another. Staff and children also reported that some are required to stay in the hospital beyond their need for hospital care because their county is unable to arrange a more suitable placement.

To address these challenges, the hospital should look to its funding structure for options. Contracts the hospital signs with counties to provide care should outline who can be served and the required information that must be made available before children will be admitted. Any child who arrives without the necessary information will result in a surcharge to the county. The hospital should establish standards on the children who will be served and the services offered. Children with other needs should only be admitted under a premium pricing structure. Counties that fail to arrange appropriate, timely placements for children ready to leave the hospital could also be charged a premium. Metropolitan State Hospital should consider its funding structure as a tool to motivate improvement in the services it provides.

Make room for innovation. A third tier of funding should promote innovation and encourage counties to invest in approaches that hold the promise of increasing the efficiency and effectiveness of mental health programs.

With three tiers of mental health funding, each with explicit incentives, the State could provide stable, discretionary funding while motivating counties to adopt best practices and continuously explore innovative approaches.

Recommendation 2: California should ensure that public or private funding is available to provide efficient, effective mental health care to all Californians.

Immediate reform should:

- ***Assess available resources.*** The Department of Mental Health should provide a comprehensive analysis of why counties are not making full use of available resources.

- ***Document costs.*** The Department of Mental Health should identify the State's share of additional costs to provide adequate services to all who need care and the consequences of not serving these children.

- ***Explore access to federal funding.*** The Department of Mental Health should explore the use of federal waivers to 1) tap into additional resources and 2) make better use of existing resources. Specifically, the department should pursue a waiver to use Medi-Cal to fund mental health services in the juvenile justice system.

- ***Form a Mental Health Insurance Task Force.*** The task force should be charged with expanding private sector insurance coverage for mental health care. It should identify the criteria for a robust private sector mental health insurance market and outline how the State could support that market. The task force should include representatives of the insurance industry, mental health stakeholders and state departments.

Long-term reform should:

- ***Revise the structure of mental health funding.*** The California Department of Mental Health should develop a plan to sunset, over time, existing categorical and grant programs and folding that funding into three sources that have the following characteristics:

- ✓ ***Stable base funding that motivates quality outcomes.*** The lion's share of mental health funding should include incentives for local mental health agencies to continuously improve services.
- ✓ ***Incentive funding for the adoption of best practices.*** A second funding stream should be used to encourage local agencies to adopt proven programs.
- ✓ ***Innovation funding to encourage experimentation and risk taking.*** A third source of funding should promote innovation and risk taking to encourage local agencies to explore new, more effective approaches to providing services.

Building a Foundation for Reform: First Steps

- ✓ The Department of Mental Health should issue a report that lists all available resources that can be used to provide mental health services.
- ✓ State associations representing local agencies should form a task force charged with developing best practices and technical assistance to ensure each county fully accesses available funding for mental health services.
- ✓ Individual counties, school districts and other local agencies should review their use of funding to support mental health services.
- ✓ The Department of Mental Health should identify counties that are not accessing all available funding for mental health and dedicate existing staff to help those counties access those funds.
- ✓ The Legislature should form a task force to determine the elements needed to provide private sector insurance coverage for mental health care for the majority of Californians.
- ✓ Local agencies should formally request that the Health and Human Services agency champion a federal waiver to use Medi-Cal funding to ensure that all children in juvenile justice programs receive mental health services. The Health and Human Services Agency should request that waiver.
- ✓ The Health and Human Services Agency should identify barriers to accessing additional federal dollars to serve children and families with mental health needs.
- ✓ The Department of Mental Health should draft a plan to collapse existing categorical funding into a three-tiered funding source for mental health services.

Invest in Leadership

Finding 3: Successful and sustained improvements in children's mental health care require an ongoing commitment to developing talented and dynamic leaders.

Children who experience mental health needs can recover to lead productive and healthy lives. Yet hundreds of thousands of children do not receive help because community leaders and policy-makers have not applied available knowledge and resources to ensure those children do not suffer needlessly. This failure to solve well-known problems is a failure of leadership.

In its previous report on the mental health system, the Commission called for renewing and bolstering the leadership role that the Department of Mental Health must play to improve the delivery of services statewide. More than 95 percent of the department's budget is dedicated to the services that it directly provides in state hospitals and prisons. Only a small portion of the department's resources are even available for understanding and improving how the vast majority of mental health clients are served by the community-based mental health system. And what resources are available are not dedicated with the endorsement of the Governor and Legislature to the "leadership" functions of identifying weaknesses and strengthening programs.[95] Without that kind of political capital, the status quo cannot be challenged or improved.

In examining mental health services for children, it became even clearer to the Commission that leadership – as defined by organizational management and political capital – are needed at both the state and local levels.

The California Department of Mental Health has the equivalent of 20 staff members dedicated to children's mental health – mostly administering categorical programs, such as Children's System of Care.[96]

State Leadership Challenges

In its report on the adult mental health system, the Commission identified a number of challenges that require leadership to resolve. Among them:

- Providing adequate funding and promoting efficient spending.
- Addressing human resource needs.
- Focusing on prevention and reducing stigma.
- Developing, documenting and disseminating promising and proven practices.
- Meeting the need for comprehensive community services.
- Managing a growing penal code client population.
- Addressing demands for reform of involuntary treatment laws.
- Implementing managed care.
- Supporting mental health parity.
- Improving oversight and accountability mechanisms.

At the state level – and in this regard California is not alone – many top administrators have not had the program-level experience to understand how bureaucracies truly work, let alone how to make them work better.[97]

At the county level, the majority of mental health directors are experienced clinicians who have advanced through the ranks to lead their departments. Few of them have formal training in managing people, administering programs or championing organizational change.[98]

Leadership is the application of attention, talent and resources to accomplish goals.[99] Leaders establish vision, develop strategy, motivate people and create the environment that enables people to be successful. The challenges of providing high-quality mental health care can be solved – if resolving those challenges is important to state and local policy-makers.

Leadership is the Missing Ingredient

Children can be eligible to receive mental health and related services through a variety of funding programs. But accessing care is difficult. Many children fail to receive adequate services because local officials have not been able or willing to address the barriers to getting care.

Losing Institutional Knowledge

The California Mental Health Directors Association has identified leadership as a fundamental challenge facing California's mental health system. In the last five years, 24 percent of local mental health directors have retired. In July 2001, 12 percent of all director positions were vacant. And another 25 percent of directors are expected to retire within the next 5 years.

Source: California Institute for Mental Health.

Medi-Cal provides access to an array of services, but many children who could be served do not receive the care they need because they have not been enrolled. Other children are ineligible or face barriers to enrollment. Children can also receive care through Realignment, the Children's System of Care, the Early Mental Health Initiative, Healthy Start, AB 3632 – the Individuals with Disabilities Education Act (IDEA) – or even CalWORKs.

But as described in Finding 2, many counties do not aggressively pursue services for children through these programs. More than two-thirds of the 1.85 million uninsured children in California are eligible for Medi-Cal or Healthy Families, but are not enrolled in these programs and so do not receive these services.[100] And advocates contend that many counties create artificial barriers to accessing IDEA and EPSDT funding. They assert that counties are hesitant to serve more children because it can mean greater demands on limited local resources, money that should be reserved for those with the greatest needs.

One county mental health director commented that counties have no incentive to identify children who need mental health care. At best, the counties struggle to help the children who ask for services or who come to their attention through law enforcement or other programs.

Similarly, information on how to provide effective mental health services to children is available, but underused. The U.S. Surgeon General has concluded that prevention programs work, and treatment and support can help a child overcome a disorder and recover.[101] Yet many children do not benefit from the high-quality services that this knowledge could foster. In short, we know how to help children who suffer with the symptoms and the consequences of mental health needs and we have made resources available, yet children suffer nonetheless.

Leadership and Confidence are Linked

The difference between counties that are streamlining access to services, creatively blending funding, stretching resources and continuously striving to improve access, care and efficiency – and those that are not – is a difference of leadership. That leadership may be in county mental health programs, at the Board of Supervisors or elsewhere but somewhere people are inspiring and engineering improvements.

For instance, a few counties have chosen not to provide a Children's System of Care program, despite the availability of resources. Others have resisted the program, despite evidence of its success. This inconsistent support for Children's System of Care, and children's mental health services in general, has reduced the confidence of policy-makers and the public in the mental health system. One response to this lack of overall confidence is to limit new expenditures and to support pilot projects over new statewide programs. In some instances, new initiatives are perceived as too costly – and policy-makers do not have the analyses necessary to justify new investments. In other instances, policy-makers are less confident that all counties are capable of effectively implementing new programs.

When resources are tight and confidence is low, mental health programs cannot compete with other programs for funding. In this environment, good programs are not expanded and thousands of children and their families fail to receive high-quality, efficient care.

Where Leadership is Needed

The mental health system suffers from a malady that is common among professional services both public and private. People are trained in the

profession, gain experience, aspire for advancement and become supervisors and managers. While some of these standouts acquire formal management training, most of them are not as prepared to manage systems as they were to practice their profession.

In addition, the administration of public programs is very difficult. Organizations are for the most part trying to address difficult problems. Personnel systems are defined by a complicated and often conflicting combination of civil service and collective bargaining rules. Funding requirements, designed to prevent the misuse of public funds, are complex and restrictive. Most public organizations must compete at one level or another for funding and the attention and support of top officials. Most public programs require the cooperation and rely on the performance of other public programs to succeed. Both locally and at the State level, these organizations are steered by a policy-making process that is necessarily political, but can make the administration of existing programs and new initiatives difficult.

Success at the program level requires a combination of practical management and political skills. Among them:

- ***Articulating a vision***. Mental health directors need to be able to establish a clear organizational vision for public programs and build the internal and external support necessary to realize and sustain that vision.
- ***Building partnerships***. Mental health programs need to work closely with schools, social services, juvenile and criminal justice programs and other agencies. Program directors must build partnerships with other public, private and non-profit agencies to best address shared goals for children and their families.
- ***Managing people***. Mental health directors must be able to rely on the support and expertise of clinical, fiscal and administrative staff in the operation of county programs. Building the necessary trust and confidence requires directors to understand and respond to the needs of staff and empower them to contribute to the best of their ability.
- ***Demonstrating political leadership***. Mental health directors must be able to assess the interest and awareness of elected officials, build public awareness and support for mental health services, expend political capital when necessary, interact with the media and community organizations, and represent the county as the local mental health authority.

Each of these requirements is made more difficult by an array of leadership challenges facing California's mental health system.

Counties Face Numerous Leadership Challenges

Like the State, local mental health agencies face a series of challenges in providing mental health care, some that are specific to meeting the needs of children. Some of the more pressing issues include:

Improving Access to Services. Local mental health agencies face two significant challenges in expanding access to services: providing care to children who could be eligible for care, but are not enrolled in Medi-Cal or other programs; and, providing care for children who are ineligible for services for other reasons.

Ensuring Adequate Care. Mental health care for some children is interrupted as they move between "systems." Each county must ensure that children receive adequate, appropriate care tailored to their needs, regardless of which agency is providing services.

Expanding Residential Placements. Many communities do not have the range of appropriate placements available, and so cannot respond to children who need that service. While the State regulates these facilities, it is up to county agencies to ensure an adequate supply of appropriate residential options for children in their care.

Finding Adequate Providers. California has a 30 percent vacancy rate for mental health professionals.[102] As described in Finding 4, the challenge of each county is to ensure an appropriate supply of trained and qualified professionals to meet the unique needs of children.

Arranging Adequate Hospital Care. Children in crisis often cannot access appropriate hospital care. Each county must ensure that an age-appropriate in patient program will be available when a child needs to be hospitalized for a mental health crisis.

Serving Transition-Age Youth. Funding rules often force counties to discontinue services as children reach adulthood – which, depending on the program and

Statewide Human Resource Challenge

Identifying and hiring adequate mental health staff is a fundamental leadership challenge facing the California Department of Mental Health and each local mental health program. The statewide human resource crisis is prolonged because the California Department of Mental Health has not stepped up to the challenge.

SB 1748 (Perata, 2000) established a task force to study and address the human resource needs in the mental health field. The bill requires a preliminary report by May 1, 2001 and a final report on May 1, 2002. The Department of Mental Health leads that task force and was allocated $100,000 to fund its operation.

As of July 2001, the task force membership has not been finalized, no meetings have taken place and the first meeting will not be held until September. In June of 2001, the department asked the California Mental Health Planning Council to staff the task force.

The department should make addressing California's human resource needs a priority: It should outline the ramifications of this challenge for the children and families who need care. It should champion the need for analyses, outreach and improved attention on mental health staffing needs to the Health and Human Services Agency and the Governor. The state Department of Mental Health should make addressing the human resource need a priority.

circumstances, is defined as age 18, 21 or 23. Addressing the needs of youth and young adults is a fundamental challenge for every county.

Coordinating Services. Many children with serious mental health needs are served by an array of local agencies, each responsible for a component of a child's well-being. A tremendous leadership challenge for local officials is to design service systems that work together toward shared goals.

Providing Culturally Competent Care. California's demographics are changing. Many Californians with mental health needs speak languages other than English and have cultural and behavioral patterns that may be misinterpreted by well-intentioned mental health staff. Each county must ensure that mental health services are attuned to the cultural and language needs of its residents.

Building California's Leadership Base

Improving the ability of each county and the State to address these and other challenges will require an investment in leadership. Local officials need the skills and support necessary to pair resources and knowledge to address needs. They need to be able to tap into the institutional knowledge of experienced leaders, to benefit from the lessons of formal administration and leadership training, and a network of peers working to address shared challenges.

The structural answer to improving leadership in mental health care is to create incentives for counties to do the right thing at the right time and to reform and streamline state and federal regulations that make it hard to do the right thing when and where it is necessary. Incentives could encourage all counties to directly invest in leadership. In the meantime, with or without structural reform, improving services will require leadership expertise.

The California Institute for Mental Health and the California Mental Health Directors Association report that many local mental health directors will soon retire. And some counties have had difficulty recruiting senior staff with the experience necessary to manage the finances and oversight of local programs. The challenges of leadership are a leading concern of both organizations, which are working to address this need. They are considering recruitment drives, training seminars, mentoring and other strategies to address this leadership shortfall.[103]

Sierra Health Foundation also has identified leadership as a fundamental challenge in California's health care field. After 16 years of grant-making, the foundation recognizes the need for health care officials to have training and support in organizational and community leadership. The foundation is funding a seven-month training program for community health leaders – including mental health – from 26 northern and inland counties. Research conducted by the foundation revealed that a significant portion of counties do not fund professional development and capacity building for their senior staff.[104]

State policy-makers should recognize that for programs such as the Children's System of Care, the Early Mental Health Initiative and Realignment to succeed, the State must support the ability of counties to be successful. The State has an interest in ensuring that the quality of mental health programs is not predicated on the ability of local mental health agencies to forestall retirement or steal experienced leaders from other programs. The State should help to ensure that local agencies can draw from a large and diverse pool of qualified, talented people who are ready to take on the challenge of leading public mental health programs. New leaders should be able to define and implement a mental health vision, assess and diagnose the need for organizational and policy reform, and challenge the status quo when children suffer unnecessarily.

There is no one strategy that best fits this leadership challenge in California. The Governor and Legislature should consider a range of responses that will ultimately increase the number of counties aggressively implementing proven and promising practices, pointing out the unintended negative consequences of existing policies, and advocating for the relief and support they need to successfully serve all families in need of care.

Recommendation 3: The Governor and the Legislature should invest in a leadership initiative that will provide existing and emerging leaders with the skills they need to be successful. The initiative should:

- ***Involve the right partners.*** The initiative should involve the California Department of Mental Health, the California Mental Health Directors Association, the California Department of Personnel Adminstration, clients and family-members, university-based experts and others to fully address the needs of current, emerging and potential mental health leaders.

- ***Cover the essential topics.*** The initiative should provide intensive, and continuing education on the topics essential to building and managing a high-quality mental health system, including:

articulating a vision, building partnerships, managing people, accessing funding, communicating goals and measuring progress.

- ***Utilize a range of strategies***. The initiative should include a range of strategies to address the needs of diverse leaders. It could provide classroom education on the latest in conflict management, personnel laws, management approaches and other on-going issues. It could provide workshops around the state on topics of particular concern, such as cultural competency, blending funding and team building. And it could convene high profile conferences to identify, explore and educate on emerging issues impacting statewide goals, such as the need for residential care, providing mental health care through the juvenile justice system and ensuring that all children with mental health needs receive adequate educational services.

- ***Offer incentives to participation***. The initiative should explore the value of a certificate program or other strategies that will encourage public and private mental health providers to determine the most cost-effective way to involve potential, emerging and existing mental health leaders in the activities of the initiative.

- ***Build capacity for continuous improvement.*** The initiative should bring together existing leaders to develop and implement special projects that offer the potential for statewide benefit and demonstrate the value of continuous improvement. The initiative could explore the potential of universal healthcare – such as the program underway in Santa Clara County - the employment of mental health clients as para-professionals, or the role of the state mental hospital in providing a continuum of services.

Building a Foundation for Reform: First Steps

- ✓ The Legislature should enact legislation to create and fund a leadership initiative under the direction of the Health and Human Services Agency.
- ✓ The Health and Human Services Agency should form a working group with statewide association representatives, researchers and other partners to outline the goals and strategies for a leadership initiative across the human services.
- ✓ The California Mental Health Directors Association should outline the skills of an effective mental health director and issue recommended training and skill standards for new local agency directors. The Association should identify training opportunities for local directors and identify funding sources to encourage existing and emerging directors to participate in formal training programs.
- ✓ Local mental health directors should solicit funding from their Boards of Supervisors to pay for their training needs.
- ✓ Local mental health organizations should advocate with local Boards of Supervisors to require and fund leadership training for local mental health directors.

Ensure Sufficient Personnel

Finding 4: Children and families are denied access to adequate and appropriate care because California has not appropriately addressed the acute shortage of qualified mental health professionals.

California lacks sufficient numbers of mental health professionals to provide the care that children and families so urgently need. Insufficient mental health personnel mean that care can be delayed or unavailable. Inadequate or delayed care can mean that needs get worse, costs rise and available treatment can be less effective. In some instances, children end up in hospitals, jails or on the streets because no one was available to care for them.

This is a well-known problem that plagues mental health programs throughout California. It also affects criminal and juvenile justice, and social service programs. Current efforts to address this problem are insufficient. Despite investing hundreds of millions of dollars in the infrastructure to track and analyze labor market needs, educate and train medical and social service personnel, and link potential employers with employees, the State has failed to adequately address this need.

Legitimate Staffing Needs

Marvin Southard, the director of the Los Angeles County Department of Mental Health, testified that more than money, his county needs the mental health staff to serve the children and families of Los Angeles.[105]

In Sacramento County, mental health leaders face similar concerns. Some 28 senior mental health counselor positions are vacant in Sacramento. Local mental health providers are offering $1,000 signing bonuses for experienced clinicians. And the county mental health program is unable to spend all of its available funding because it cannot hire or contract with adequate numbers of children's mental health specialists.[106]

California cannot expand high-quality mental health care, enhance prevention, and improve the efficiency of care without sufficient mental health personnel.

California's Human Resource Crises

California is facing human resource crises in a number of fields, particularly in health care. Public and private sector health care providers are struggling to hire an adequate number of nurses, child psychiatrists, case managers and others professionals. Difficulty finding adequate personnel is particularly acute for positions that require personnel to understand distinct cultural, language and age-related needs.

California's ability to ensure that children and adults receive adequate mental and physical health care and social services, and receive appropriate care in juvenile and criminal justice programs will require the State to do a better job of meeting workforce needs in these essential fields.

The California Mental Health Planning Council has documented the shortage of qualified, trained mental health professionals. The Council found a 50 percent vacancy rate for psychiatric technicians statewide and a 30 to 36 percent vacancy rate for other positions. It takes 12 months to fill a psychiatric technician position or to hire a child psychiatrist and 4 to 7 months to hire social workers.[107]

In the northern region of California, shortages are more dramatic. One northern county has a psychiatrist position that has been vacant for more than two years.[108]

Insufficient Mental Health Personnel

According to the California Mental Health Planning Council, the vacancy rates for mental health professional positions statewide exceeds 30 percent.

- In the Bay Area it takes four months to fill a licensed clinical social worker position.
- In the Central Valley, it can take 10 months to fill similar positions.
- Los Angeles County has a 30 percent vacancy rate for psychiatrists.
- In the northern region, it can take almost a year and a half to fill vacancies for psychiatrists and psychologists.

Even Southern California counties – with their larger populations, greater numbers of colleges and universities, and larger workforces – face problems. Los Angeles County reported a nearly 50 percent vacancy rate for child psychiatrists, an 80 percent vacancy rate for licensed social workers, and a 60 percent vacancy rate for psychiatric technicians.[109]

Health care in general is facing a human resource crisis, although mental health may be particularly impacted. Research by the Center for the Health Professions at the University of California, San Francisco reveals that some regions of the state have insufficient numbers of medical providers, and as a whole, California lacks sufficient specialists, such as psychiatric specialists.[110] Providers willing to work with Medi-Cal clients are particularly scarce because of the paperwork involved and low reimbursement levels. The California Medical Association reports that over half of all Medi-Cal patients have difficulty finding physicians who will accept Medi-Cal payments.[111] The Center for the Health Professions confirms this need.[112]

Limited Staffing Can Lead to Unnecessary Suffering

When staff are scarce, services are unavailable, needs go unmet and costs rise. The U.S. Surgeon General confirms that when needs are met early, treatment can prevent the exacerbation of symptoms and progression of needs.[113] Unaddressed mental health needs can lead to higher, longer-term costs.

Nancy Presson of San Francisco's mental health department testified that competition for a limited pool of children's mental health workers might be the single greatest barrier to expanding mental health care for children.[114] Donna Dahl, the Children's Services Manager for the Riverside County Department of Mental Health, argued that it is particularly difficult to recruit mental health staff with bilingual skills and diverse cultural backgrounds.[115] The Children's Summit III, a public agency partnership focusing on the mental health needs of children, argued that without an adequate pool of potential employees, the service delivery system will fail.[116]

The expansion of children's mental health care, particularly through the Children's System of Care and EPSDT, has increased the demand for children's mental health practitioners, and in some cases exhausted the supply of children's clinicians. This shortage is exacerbated by competition among county mental health and social service programs, probation departments, and private mental health providers looking to recruit, hire and retain specialists.

When mental health providers cannot recruit and retain adequate mental health staff, children and their families suffer. Limited staffing contributes to long delays in accessing services or poor quality care. Multiple news stories capture the anguish and suffering of people who fail to receive timely care.

A teenage girl slit her wrists after trying to see a psychiatrist four separate times. The girl was rushed to the hospital by ambulance then taken to the county psychiatric hospital where she was asked to sign a contract promising not to attempt to take her own life. She was released 45 minutes after signing. That was her second promise. Another girl was told the wait to see a psychiatrist is two months.[117] In one northern county, patients sometimes have to wait eight weeks for medication appointments.[118]

Children and families from diverse ethnic and linguistic communities can be particularly impacted. In one community a woman who speaks a particular Chinese dialect was sent to a psychiatric in-patient facility where no one spoke her language. For over a year she wanted to move to a community-run facility where staff could communicate with her and improve her treatment. Her requests went unheeded because no one could understand her.[119] There also is evidence that children from diverse cultures can be inappropriately directed into mental health treatment for what are in essence cultural attitudes and practices because there are inadequate numbers of qualified clinicians to work with them.[120]

Current Efforts

Several public entities are working to address California's mental health workforce crisis.

- ✓ Senate Bill 1748 (2000, Perata) created a task force led by the Department of Mental Health to identify options for meeting the staffing needs of state and county health, human services and criminal justice agencies. The task force was directed to report its findings to the Legislature by May 1, 2002.[121]
- ✓ The Assembly Human Services Committee has held public hearings to develop an action plan to address the workforce shortage throughout California's human services fields.
- ✓ The University of California (UC) has received a grant from the California Endowment to assess the need for health care professionals and the capacity of the UC to meet that need.
- ✓ The California Mental Health Planning Council continues to work to identify barriers to increasing the supply of workers and has recommended strategies to address this need.
- ✓ The California Psychiatric Association has established an Access Task Force to assess the extent that people have access to psychiatric care. Their review looks at the value of tele-medicine and improving the ability of primary care clinicians to assess needs and receive consultations from psychiatric specialists.[122]
- ✓ SB 632 (Perata) and AB 1422 (Thomson) were introduced in 2001 to provide additional resources to address staffing shortfalls through new training opportunities, loan forgiveness programs and other strategies.

While some progress has been made, a comprehensive, long-term solution to this need has not been proposed.

Potential Workforce Development Barriers

California's Employment Development Department estimates that between 1998 and 2008, public and private providers in California will need to fill 45,000 mental health positions.[123] There has been no analysis that could explain why the labor market is not providing adequate personnel to fill these positions.

There are many potential barriers. Supply is certainly an issue. SB 632 and AB 1422 strive to increase the number of graduates with mental health-related degrees. The California Mental Health Planning Council

also attributes bureaucratic barriers within county government as a contributing factor. The Assembly Human Services Committee has heard that a poor image limits the number of people willing to enter human service fields. Across these multiple efforts, the following barriers have been identified:

- Inadequate supply of trained staff.
- Complex hiring rules cause undue delay.
- Poor public image of the field turns away potential applicants.
- Stressful workloads discourage new entrants and increase turnover.
- Poor alignment of training with the realities of the workforce limit retention.
- Limited support for staff and professional development encourages turnover.
- Low pay and benefits reduce the attractiveness of the profession and retention.

Unfortunately, there is no comprehensive analysis of these barriers, how they interact, or where attention should be concentrated. The Planning Council is examining the supply of graduates from California's public and private institutions. The Assembly Human Services Committee is working with a UC Berkeley researcher to understand the barriers to expanding training opportunities in public colleges and universities. The State has not explored whether students graduating from mental health related fields are choosing to work in other fields or in other states. Also unexplored is the role that streamlining county bureaucracies, wage increases, reduced workloads or other strategies might play in addressing this need.

Some have argued that California prisons and juvenile justice facilities have had difficulty hiring mental health specialists because many people choose not to work in a correctional facility. Others have argued that the location of many of these jobs, particularly in remote correctional institutions, also creates hiring barriers that are not easily addressed.

California's Workforce Development Resources

California has multiple workforce development resources. These entities, with their knowledge and experience, could be harnessed to help address the staffing crisis in mental health. Fundamental concerns should be whether this crisis could have been prevented, whether the next will be avoided, and whether state and local agencies have sufficient data and technological know-how to track conditions in other vital industries.

The Office of Statewide Health Planning and Development has a Health Development Program charged with "attracting and enabling the diverse population of the state to pursue medical careers." The office provides direct grants to training programs, does outreach, offers financial assistance and creates links between potential employees and potential employers.[124]

The Employment Training Panel within EDD is charged with ensuring that California's employers have access to the skilled workforce they need to be successful.[125] And the Economic Strategy Panel and State Workforce Investment Board were created to ensure that government supports leading industries in California to be successful and does not present undue barriers to the viability of high wage industries.[126] Health care is an industry that is crucial to the high quality of life in California. When the health care industry in California stumbles, lives are at risk.

Each of these entities could be charged with ensuring that the multiple, existing efforts to address the state's mental health workforce needs are coordinated, integrated and successful.

University of California – Office of Statewide Health Planning and Development Memorandum of Understanding

In 1993, the University of California and the Office of Statewide Health Planning and Development entered into a Memorandum of Understanding (MOU) regarding the number of doctors UC would train from 1993 to 2001.

The MOU was drafted after the Legislature and OSHPD determined that UC was training too few general practitioners. The MOU was intended to ensure that OSHPD and UC worked toward common goals – producing more general practitioners.

The MOU, which expires in 2002, is identified as one of the primary reasons why UC is unable to train more health care specialists, such as child psychiatrists. For the last few years UC's medical schools have been turning away doctors hoping to train in psychiatric specialties.

California has 61 training slots for child psychiatrists in public and private institutions. At UC Irvine, the psychiatry program formerly admitted 12 new residents, but is limited to 8 under the MOU. The department has the capacity to train 16, if given adequate resources.

Dr. Barry Chaitin, M.D., Clinical Professor and Co-Chair of the Psychiatry program at UC Irvine suggests that it will take 6 to 7 years to increase the supply of child psychiatrists because training takes four years and it can take three years to increase training opportunities.

Source: Office of Statewide Health Planning and Development.

California's Workforce Infrastructure

California has the infrastructure to understand and respond to workforce problems that diminish the ability of health and human service agencies to meet the needs of clients. But those efforts are not coordinated, and as a result are ineffective. Long-term solutions will require cooperation.

Forecasting & Planning

Several California departments and programs forecast and respond to workforce development needs.

- **California Workforce Investment Board.** The Board assists the Governor in restructuring workforce development programs into an integrated workforce investment system.
- **California Economic Strategy Panel.** The Panel is charged with improving the ability of government to respond to the workforce needs of significant industries.
- **Employment Development Department.** The department collects and analyzes labor market data and helps ensure employers have the trained workers they need.
- **Regional Collaboratives**. Five regional collaboratives assess regional workforce development needs and formulate responses.

Forecasting and training agencies assess needs and target resources to meet them

Cooperation could produce an ongoing strategy for ensuring an adequate health care workforce.

Educational institutions train future workers

Health agencies work with providers to understand needs

Education/Training Resources

Four separate public entities provide educational and training opportunities to adults.

- **Adult Education Programs.**
- **California Community Colleges**.
- **California State University**.
- **University of California.**

Between these four entities, California can educate and train the professionals needed to staff the healthcare positions throughout the state.

Health Agencies

California has several departments and offices equipped to address workforce needs in the health care field.

- **Department of Mental Health**. California's lead mental health agency.
- **California Mental Health Planning Council**. The council provides oversight of the public mental health system.
- **Office of Statewide Health Planning and Development**. Supports the development and expansion of health training and promotes recruitment into health professions.

Strategies to Consider

Policy-makers should consider multiple strategies to address staffing needs. They should ensure that all strategies are well-aligned with actual barriers that prevent more people from entering and remaining in the mental health field.

Hiring Clients

Several counties are hiring and training clients to provide mental health services. Some administrators argue that former and current clients are best prepared to do outreach, provide treatment, case management and other services because their experiences as mental health clients improve their ability to work with others with mental health needs.

Sacramento County also has recruited youth with experience in the mental health system to serve on policy boards and work as mentors.

Recruitment. It is unclear if other states are facing similar staffing challenges. State licensing requirements are not consistent across states and California has not developed reciprocal licensing arrangements that would allow the state to recruit nationally. California should investigate the extent that licensing requirements present a barrier to national recruitment. Policy-makers could pursue provisional licensing programs that would allow out-of-state practitioners to work in California while reciprocity agreements are developed or these practitioners are licensed in California.

Training Academies. Some counties - Sacramento and Los Angeles, for example - have developed training academies in conjunction with local community colleges and state universities. A training academy allows an individual to study while gaining on-the-job experience with a mental health agency. Sacramento County provides employees 20 hours per week of paid leave time to participate in a psychiatric technician program. Unfortunately, not all community colleges and public and private universities offer relevant programs. Sacramento County employees travel to San Joaquin Delta College in Stockton because the community college district in Sacramento does not offer a psychiatric technician program. The community colleges are statewide resources that could become excellent training partners with county mental health programs.

Scholarships/Loan Forgiveness Programs. AB 1422 and SB 632 proposed financial assistance to remove financial barriers to students entering mental health professions. The Office of Statewide Health Planning and Development provides financial resources to increase the number and distribution of trained medical personnel in California. Additional investment in this strategy should assess the effectiveness of existing efforts and ways to improve the efficiency and cost-effectiveness of these programs.

Workload Analysis. The Commission has received testimony that unbearable workloads and onerous reporting requirements discourage clinicians from working in the public sector. In some counties working conditions have lead to union grievances and are implicated in high turnover rates. A workforce analysis should assess the extent that vacancies are caused by people moving out of the mental health field rather than simply a limited supply of qualified workers.

The Cathie Wright Technical Assistance Center

The Cathie Wright Technical Assistance Center was established in 1997 with state mental health funds to support the expansion and improvement of mental health services to children. The Center is one resource available to California to improve the core competencies of mental health professionals.

Core Competencies. The Commission received reports that many new employees are entering the field without the necessary training and experience required to provide high-quality care. In some instances, new employees are learning treatment and management strategies no longer in favor or proven to be ineffective. In other instances, training curriculum is not aligned with the needed job skills. Workforce development efforts should assess the alignment of training programs and the needs of the field.

Next Steps

This staffing crisis is a problem waiting to be solved. It does not require the development of pioneering technology, scientific discovery or dramatic increases in spending. It requires the political leadership of state and local policy-makers to make it a priority. California's mental health system will not improve if policy-makers do not assess the barriers to moving more trained, skilled employees into mental health professions.

California has the infrastructure to solve this problem.

- EDD offers the technical knowledge to forecast needs and assess trends in mental health employment.
- The Office of Statewide Health Planning and Development has the experience to move people into health fields.

Data Analysis

The Employment Development Department receives detailed data on who is employed, the industries they work in and their wages.

UC, CSU, the community colleges and the California Post Secondary Education Commission (CPEC) have detailed data on the coursework and graduation dates of people trained for mental health and human service fields.

By matching training and employment data, researchers could address the questions significant to this staffing shortage, including:

- Are graduates from related fields working in mental health positions?
- What is the retention rate for new hires?
- Are mental health professionals moving out of public sector positions?
- Do some counties face greater retention barriers than others?
- What role does compensation play in retention across counties?

Most importantly, thoughtful analysis could suggest where state and local agencies should focus their efforts to address staffing shortages.

- The Employment Development Panel and the community colleges have the capacity to link employers with training and education providers.
- The Regional Collaborative model could be expanded to address the human service workforce needs across the state.

But these efforts should not happen in an independent or fractured manner. Human service workforce development efforts should be coordinated and continuous. They should capitalize on the forecasting and data analysis skills of the EDD and identify emerging needs before they reach crisis proportions.

Recommendation 4: The Governor and the Legislature should direct the Health and Human Services Agency to address this crisis. Specifically, the legislation should:

- ***Call for a human service workforce summit.*** The Health and Human Services Agency should convene a human service workforce summit to better understand and address the personnel needs of public and private sector human service employers and personnel. The summit should bring together public and private agencies and organizations working to address this issue. The summit should:
  - ✓ ***Document needs.*** The summit should bring together researchers and others to clarify the present and future human service workforce needs in California.
  - ✓ ***Document barriers to entering the workforce***. The summit should identify and clarify the barriers that make it difficult for people to enter the human service workforce. Barriers to be considered should include inadequate supply of trained personnel, compensation, workload, work environment and any other factors considered to impede the recruitment and retention of qualified human service employees for public sector and private sector employment.
  - ✓ ***Identify strategies to respond***. The summit should identify the present capacity of California to respond to these barriers. It should document where present capacities are inadequate. And it should identify strategies for improving the ability of public and private training institutions, public and private employers, guilds, unions and others to work together to improve the capacity of California to respond.
  - ✓ ***Review the appropriateness of expanding the use of para-professionals in mental health and related fields.*** Expanding the use of practice models that rely on mental health clients, peer support groups, and other para-professionals to address mental

health and related needs could improve access to care and address staffing needs.

- ***Assess overlap, duplication and gaps of mission, authority and funding of workforce development programs.*** The Health and Human Services Agency should form a task force to review the allocation and organization of existing workforce development resources and make recommendations to reduce duplication and conflict. The task force should:

  - ✓ ***Identify unmet needs.*** The task force should assess whether California has adequately invested in workforce development and can respond comprehensively to workforce needs. It should include recommendations for improvements.

  - ✓ ***Document the ability and incentives of workforce development programs to work together to forecast needs and formulate responses.*** Public entities should work together to address needs and strive to continuously improve California's response to workforce development needs.

  - ✓ ***Review the appropriateness of existing data, data analysis and forecasting models.*** The task force should review whether the Employment Development Department and its programs are presently able to accurately reflect and respond to the realities of a changing workforce and workforce needs and how those programs can be improved to guide the efforts of policy-makers interested in improving workforce development.

Building a Foundation for Reform: First Steps

- ✓ The Legislature should direct the Health and Human Services Agency to convene a human services workforce summit.
- ✓ Statewide and local mental health organizations should collectively ask the Health and Human Services Agency to detail the efforts underway to address present workforce needs and align ongoing research and intervention programs to ensure adequate and culturally competent personnel are available as the need for mental health services evolves.
- ✓ Local mental health departments should develop partnerships with community colleges, CSU and UC campuses to align training programs with the demands of employment. Where necessary, local Boards of Supervisors should be encouraged to ensure that community college leaders prioritize public sector workforce needs when determining how to best use limited community college resources.

Remember the Child

Over the last 8 years the Commission has examined how California assists struggling children and families. The Commission has looked at how children become involved in crime and violence or end up in the juvenile justice system and what happens to them when they do. It has looked at the constant struggle to make sure each child has the chance to learn in a safe, well-equipped classroom with the most capable of teachers. It has looked at how California cares for those children who lose their parents or who grow up in threatening and abusive households and end up in the foster care system. And now it has looked at how children are served by the public mental health system.

Many of the concerns raised during those projects were repeated here. Children and families face insurmountable barriers to accessing the care they need. They are served by multiple agencies with overlapping and contradictory rules. Few find reliable information that can guide them through the service delivery system and ensure they receive necessary care. And policy-makers and the public do not consistently and reliably know when public programs are working and when they are not.

The Commission's advisory committee identified these and other barriers that prevent families from obtaining the mental health care a child needs. The majority of the issues raised by these mental health experts – and many others who are struggling to make the present service system work – cannot be resolved by mental health professionals alone. The challenges facing children with mental health needs and their families also involve child welfare, juvenile justice, education, substance abuse treatment, social services and other programs.

Little Hoover Commission Reports on Child and Family Policy

Never Too Early, Never Too Late…To Prevent Youth Crime & Violence (June, 2001)
Being There: Making a Commitment to Mental Health (November, 2000)
To Build a Better School (February, 2000)
Now in Our Hands: Caring For California's Abused & Neglected Children (August, 1999)
Caring For Our Children: Our Most Precious Investment (September, 1998)
Dollars and Sense: A Simple Approach to School Finance (July, 1997)
Enforcing Child Support: Parental Duty, Public Priority (May, 1997)
The Charter Movement: Education Reform School by School (March, 1996)
Boot Camps: An Evolving Alternative to Traditional Prisons (January, 1995)
The Juvenile Crime Challenge: Making Prevention a Priority (September, 1994)

As part of this report – and drawing from its previous work – the Commission offers this finding and recommendation as a strategy to begin needed reform. The present system fails more children than it serves. It is broken to the point of needing replacement. A new categorical program – an infusion of more money alone – will not cure this system. And attempts to treat one part of the service delivery system will just reveal weaknesses in another. California must design and fund a service delivery system around the needs of children and their families. California can provide better services, to more people, at less cost, with less frustration and heartache – both for the caring professionals and the people they serve. This recommendation outlines the steps to redesigning that system.

Serve Children and Families

Finding 5: California does not fund, organize or administer services to comprehensively meet the needs of children and families.

In the first four findings of this report the Commission identified ways to improve mental health services to children. It recommends expanding opportunities for prevention, establishing access and quality goals, and providing the three ingredients needed to sustain improvement: focused and supported leadership, resources with incentives and discretion to do the right thing at the right time, and sufficient personnel to serve the children who need care. If California were to make those improvements the mental health system would serve more people at lower costs. But the need and the opportunity are much greater. The Commission found that to make substantial improvements in services for children, the State would need to look at mental health in the context of other services.

Children Have Multiple Needs

Nearly 850,000 children in California experience a mental disorder each year. Many of these children – including those most at risk of long-term needs – are already in "the public service system." The problem is that it is not a system at all, but disjointed and isolated programs. Juvenile justice is distinct from foster care. Educational systems are distinct from health care. Mental health is distinct from physical health. And housing and substance abuse are barely at the table.

As described previously, public service providers know about the mental health needs of their children. Yet despite that knowledge, in some counties, data show that only about half of the children in foster care who need mental health services are receiving the treatment they need.[127] In others, juvenile facilities are used to house children with mental health needs because there are inadequate treatment facilities.[128]

The following statistics demonstrate the need for a true "system of care":

- 72 percent of children in child welfare programs have severe emotional disturbances.[129]
- 68 percent of children in dependency courts have signs of a mental disorder.[130]

- 50 to 80 percent of children in the juvenile justice system have mental health needs.[131]
- Two-thirds of the children with an affective disorder also experience a substance abuse/dependence disorder.[132]
- Nearly 50 percent of children with emotional or behavioral disorders drop out of school; only 42 percent of those who remain graduate.[133]

The parents of children served by multiple programs, providers and agencies have the most telling stories. So often the difficulties begin with school failure. Some children are kicked out of child care programs. Unsure of what is happening with their children, parents don't know where to turn. As one witness explained, parents must become experts in navigating bureaucracies before their children receive adequate care.[134]

Yet even experts have difficulty arranging appropriate services. Many parents turn to attorneys and the courts to force local agencies to provide the services their children are entitled to receive.

Tim Needs Multidisciplinary Services

Tim could benefit from a range of services. To address his wide-ranging needs the county will have to bring together a diverse collection of services into a coherent package. As stated in his assessment documents:

> Tim is 12 years old. He is on probation for molesting his foster parent's 6-year-old grandson. He has attention-deficit/hyperactivity disorder. Tim and his siblings were removed from his home when he was 8 due to severe neglect. He was subjected to domestic violence when his father was using drugs. He was exposed to his parents having sex at a very young age. A 15-year-old male cousin molested him. His small stature and ADHD make him the target of teasing. Plagued with self-doubts, he is periodically sad, empty and lonely. He yearns for a stable home environment. He feels helpless and wants nurturing and support. He has above average intellectual skills but his behavior and emotional problems have a very negative impact on his ability to profit from education.

Tim is in the custody of county probation. A comprehensive assessment recommended that Tim be placed in foster care where he will not be vulnerable to other youth. He needs sex-offender treatment, supportive individual therapy for his victimization, his role as a perpetrator, the abandonment, abuse and neglect. He needs substance abuse education, anger management and social coping skills training. Lastly, he needs a full educational assessment to see if he qualifies for special education services. He needs a highly structured, supportive and encouraging learning environment.

In many respects, Tim is typical of the children who enter the children's service system and the response he receives from his county is standard across the state. He needs multidisciplinary care to address multiple, interrelated challenges. Ideally, Tim would receive a package of services designed to build on his personal and family strengths and return him to living independent of public social services. In reality, there is little hope that Tim will receive the services he needs. Funding rules stipulate the services that are covered and he has needs that fall outside that approved service list. His county would need to tap into discretionary funding to address his needs and his local Board of Supervisors has chosen not to do so. As a result, there is no mechanism to access services across multiple service delivery systems. And no single person or department has the authority or responsibility to ensure that Tim's needs are met.

Single Programs Cannot Meet Those Needs

State and federal policies drive the organization and funding of programs for children and families. Like other areas of public policy, children's policies have been developed incrementally. A need exists, a program is developed, funding is provided and the gap is filled. Yet after a decade of filling gaps, it has become more burdensome to administer, fund and even navigate multiple discrete programs than was ever the intention.

Organization. California has three state agencies and nine separate departments that provide services, fund and assist or regulate programs serving children.[135] Other than the Governor, no single department, agency or individual within the State is responsible for meeting overarching goals.

No one is accountable for the impact of disparate decisions that effect outcomes of individual children or families. Moreover, programs and their managers are insulated from accountability by the complexity of funding and regulations. Parents, policy-makers and the public have a hard time deciphering which funding stream, which administrator and which decision caused a particular child to receive a set of services or fail to receive services. As outlined in Finding 1, many children fail to receive the care they need despite the enormity of public programs to serve them.

Funding. As discussed in Finding 1, funding is often restricted to serve certain populations, to provide only certain services. These are all restrictions intended to ensure a certain problem is solved or to prevent the misuse of funds. But people and their problems do not always fit into programs that are compartmentalized by agency, program, funding source or diagnosis. As detailed in Finding 2, the result is ineffective, inefficient programs that create dramatic inequities across counties and families. Services are not available based on what it would take to most cost-effectively respond to needs.

Program Integration Could Improve Outcomes

Increasingly policy-makers and child and family professionals have called for the integration of child and family services.[136] They recognize that disparate programs, funding sources, regulatory structures and oversight mechanisms result in narrowly defined, uncoordinated care that is inefficient, confusing and often leads to contradictory treatments. Efforts to coordinate care have resulted in improved outcomes. But, coordination can require an inordinate amount of staff time, as multiple sets of regulations, licensing requirements and reporting standards limit the ability of counties to further improve the efficiency and effectiveness of care.

The CTF: A Case Study in Organizational Chaos

Santa Clara County is one of California's pioneering counties. Local efforts to meet the mental health needs of children have been thwarted by state agencies that complicate and confuse local efforts. Building a Community Treatment Facility in Santa Clara demonstrates the challenges of working within California's approach to organizing and funding services.

In 1993 California enacted legislation (Chapter 1245, SB 282 Morgan) authorizing counties to develop locked treatment facilities, known as Community Treatment Facilities (CTF). They are intended to support children who need more structure than traditional facilities, but fewer services than are available through an inpatient hospital setting.

Santa Clara County has California's first operational CTF. It is operated by a private contractor. The CTF has three components: a residential setting, a mental health treatment program and a non-public school to educate children while in residence. Each component of the program has separate funding, licensing, staffing requirements and accountability mechanisms. Each component works with separate local agencies, which in turn respond to separate state agencies.

As a group home, the California Department of Social Services (DSS) licenses the residential component. The DSS worked with the Santa Clara County Department of Child and Family Services to develop a rate structure and staffing requirements that would meet DSS regulations. Children sent from the foster care and juvenile justice systems are eligible for federal funding to cover residential costs. Other children may not be. The facility must determine the eligibility of each child and bill the appropriate agency to fund residential services.

The California Department of Education (CDE) licenses the educational component of the CTF. The contractor worked with the Santa Clara County Office of Education to establish a schooling program that would meet state standards and could be coordinated with local public school programs. Educational services are funded through CDE in a manner similar to how public schools are funded.

As a mental health treatment facility, the California Department of Mental Health (DMH) was required to certify the treatment component of the program. Santa Clara County Mental Health worked with the DMH and the contractor to design a staffing and treatment program that would meet state standards. For most children mental health funding is available through state and federal sources. Local funding sources also are necessary to supplement that funding.

With three components that must comply with three sets of regulations, there is bound to be conflict. In fact, development of the facility was delayed because initial DSS and DMH rules were contradictory. DSS requires group homes to reach 90 percent of capacity within six months of opening. The regulation is designed to ensure that facilities maintain adequate staffing levels. DMH and Santa Clara County expressed concerns about certifying a facility that would grow so quickly that is serving children with significant mental health needs. DMH wanted the facility admissions to grow slowly to ensure that children would receive adequate care. The issue was resolved through a negotiated rule waiver once DMH and DSS discussed the goals of the program and barriers to its success.

Source: Santa Clara County

Service integration is often premised on the following standards:

- ***Consistent care regardless of how the system is accessed***. Access to services is currently determined by how children come to the attention of local officials. Children in different programs receive different services. Integration can ensure that all children receive a high level of care regardless of whether they enter the public service system through mental health, juvenile justice, schools or other programs.

- ***Comprehensive services to meet a full range of needs***. Children and families struggle to piece together a package of disparate services into a comprehensive program. Integration can ensure that children receive comprehensive, strength-based services designed to support their long-term self-reliance.

- ***Consistent care as children age or needs evolve***. As children age they can lose eligibility for services or must transition between programs. As they move from one school district to another, or between treatment programs, the care they receive changes. That inconsistency can prolong the need for services. Integration can help children receive consistent services as they age or their needs evolve.

- ***Single point of responsibility and accountability for outcomes***. The confusing tangle of funding sources, service providers and public programs requires families to become experts before they know who is in charge and responsible for providing the services they need. Integration can establish a single point of accountability to make it easier to evaluate results, implement change and hold decision-makers accountable for outcomes.

- ***Services target long-term individual, family and community goals***. The current disparate nature of child and family service programs creates incentives for administrators to adopt a narrow, short-term focus that is crisis driven. Local agencies are almost encouraged to practice competitive cost avoidance by sending children who need expensive care to other programs. The juvenile justice system routinely receives children that other programs have failed to serve. Integration is intended to create a partnership between programs around long-term prevention and efficiency.

Defining Integration

The concept of service integration has a 30-year history. Where attempted, integration has had mixed results. Service integration can involve a variety of strategies and can mean more than the creation of a "super-agency" which is commonly considered the primary strategy for integrating services.

In the context of this report integration refers to multiple agencies linking their responsibilities and accountability for caring for children and their families. It means bringing together services and funding from multiple sources into a shared strategy to provide the highest quality, most efficient care possible.

Integration proponents assert that integration that allows local agencies to make resources and staffing decisions locally can dramatically improve their ability to focus on prevention, make more efficient use of limited funding and allow accountability mechanisms to focus on outcomes on a broad array of indicators.

Promoting Service Integration

Importantly, the State knows that integration can improve the efficiency and effectiveness of services and has even directed counties to do so. But the State has not adequately addressed the barriers that make integration difficult and creates disincentives to integration.

The drive for service integration has been pushed by greater recognition that children with significant needs in one area of their life often have similar needs affecting other areas of their life. California has initiated several programs described below to integrate care for children and families to address the full range of needs that children present. Some counties have found success with program integration and have improved the quality and efficiency of services. Other counties are leery of integration efforts and have not pursued these programs.

Children's System of Care. (AB 377, 1984) The Children's Mental Health Services Act implemented the Children's System of Care model for serving children with mental health needs. Under a system of care approach, children with serious emotional disturbances receive multi-agency, multi-disciplinary care.[137]

"Ann" is Dancing as Fast as She Can

Improving access to care and promoting the coordination of services is insufficient to serve children and families with multiple needs. Consider "Ann" and her children. She is determined to make the system work for her family. But the system does not make it easy for her.

Many families are strained by the complexity and competing demands of multiple public programs. Ann, a northern California resident, is struggling to address her mental health and substance abuse needs and the mental health and education needs of her children.

After release from jail for her drug use, Ann has been living in a transitional housing program. To address her needs, she meets with a mental health worker one day per week. She attends Alcoholics Anonymous meetings three days each week. She is working to be reunified with her three children. The county requires her to attend parenting classes. One of her children is the victim of sexual abuse. The county requires her to attend a program for parents of sexually abused children.

Ann has additional meetings to attend with her children. Her youngest son is struggling in school and she strives to attend all parent-teacher meetings. Her middle child is in a school for children with serious emotional disorders. She is required to participate in family meetings and team meetings to monitor and participate in her son's education. Her oldest child is seeing a county psychiatrist and a mental health therapist. Both want her to attend portions of the meetings they each have with her son.

Ann is fortunate to own a car. The county provides gas vouchers to help pay her transportation costs and there is no adequate bus service should she have to rely on public transportation. In all, Ann is dancing as fast as she can to make the system work for her family.

Healthy Start Support Services for Children Act. (SB 620, 1991) Healthy Start brings together school districts, education, social service, mental health and health agencies, non-profit organizations and others to provide school-linked services to children that can enable them to be successful in school and other areas of their lives.[138]

California Early Intervention Services Act. (SB 1085, 1993) The California Early Intervention Services Act implemented the California Early Start program. Early Start links regional centers, local educational agencies and child care agencies to target services to children ages zero to three who experience developmental delays and their families.[139]

Youth Pilot Project. (AB 1741, 1993) The Youth Pilot Project established a five-year pilot project (1996 – 2000) that would allow six counties (Alameda, Contra Costa, Fresno, Marin, Placer and San Diego) greater discretion over how state funding can be used to encourage them to integrate services.[140]

System of Care: Definition and History

A system of care is a "comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple and changing needs of children and adolescents."

California's system of care program was initially developed in Ventura County. It was designed to serve a target population of seriously emotionally disturbed children. The approach has been expanded to 53 of California's 58 counties.

For some counties, it has become a new source of funding. Others have used this funding to drive the way they provide care, but only because it is one of just a few sources of discretionary funding. A true system of care would allow counties full discretion in how resources are used to address needs whether mental health, physical health, drug and alcohol treatment, education or violence.

SB 933. (1998) SB 933 changed portions of the foster care system. Under the statute, counties that wish to place children in residential facilities outside of California must bring together multi-disciplinary, multi-agency teams to assess and develop a placement plan.[141]

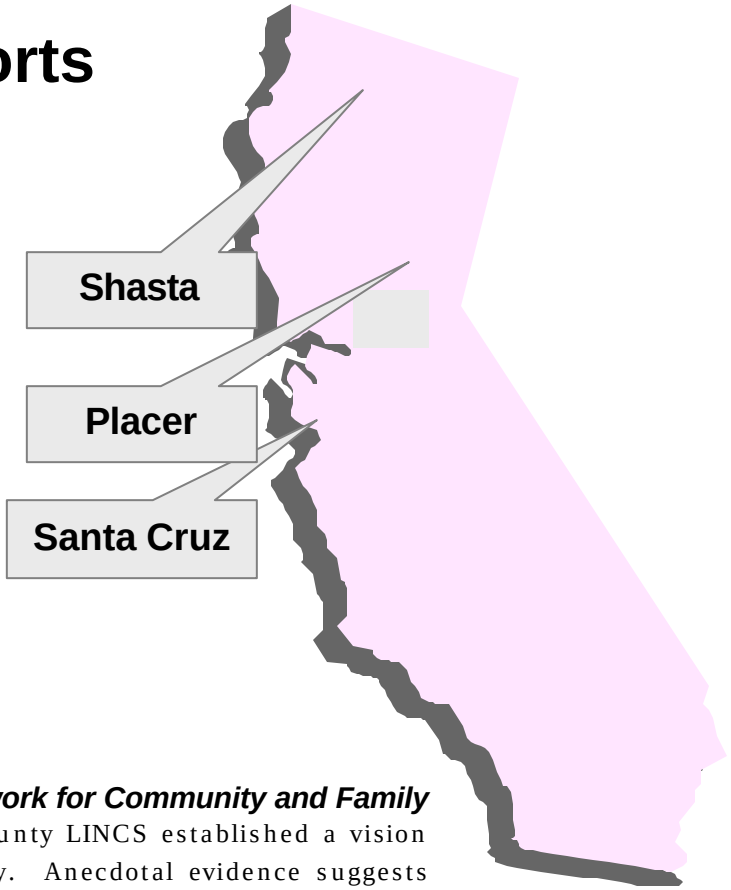
AB 1259. (Chapter 705, 1999) AB 1259 created the County Integrated Health and Human Services Program to allow Humboldt and Mendocino counties to blend funding and services to improve the delivery of care.[142]

Coordinated School Health. (2000) The California Department of Education has issued a report, *Building Infrastructure for Coordinated School Health: California's Blueprint*. The Blueprint calls for an interagency system of supports for children and their families.[143]

Each of these programs recognizes that the needs of children and families transcend the services available from a single state or local department. Yet no county has integrated services for children and families across the board. AB 1741 and AB 1259 offer the greatest hope that counties could blend funding and design services to meet the needs of children and their families, but they have removed few of the barriers that thwart integration.

Three County Efforts

Many counties have taken advantage of state-sponsored opportunities to integrate services. Several have organized those efforts around core goals for children and families. The challenge for the state and local mental health leaders is to learn from those lessons, remove barriers to success and align the organization and funding of services with the realities facing children and families in need.



Shasta County Local Interagency Network for Community and Family Services (LINCS). In 2000, Shasta County LINCS established a vision statement for all children in the county. Anecdotal evidence suggests LINCS has dramatically improved services to the children being served through the foster care system. Under that vision, children and youth should be safe, healthy, in school, out of trouble, have real permanency, and a chance to become productive citizens. The program defines each goal as follows:[144]

- *Safety. Children have the right to be safe and parented with dignity in their own home, in kinship care or in the foster care system.*
- *Health. Children need to be healthy in mind and body. They require comprehensive medical, dental, and mental health care. They need to grow up in an environment of normalcy.*
- *Education. Children need to be successful in school, be able to graduate, and to learn the skills needed to enter adulthood.*
- *Out of Trouble. Youth need to be raised with tolerance and care to teach them to avoid delinquency, substance abuse or unwanted pregnancy.*
- *Permanence. Youth need to return to family or to be placed in guardianship or adoptions in as timely a manner as humanly possible.*
- *A Future. Youth who age out of the foster care system should have a place to live, a job and the chance to go to college.*

Placer County Systems Management, Advocacy and Resource Team (SMART). Since 1988 Placer County has been working to build a multi-agency services collaborative called SMART. In 1994 SMART used state System of Care funding to co-locate and better integrate services. The Placer County project has tracked a set of outcomes that are shared by each social service department participating in the SMART program. Placer County tracks indicators that reflect the following goals:[145]

> *all Placer County families would be self-sufficient in keeping their children safe, healthy, at home, in school, and out of trouble.*

SMART is designed to reinforce the notion that all agencies are responsible for all outcomes.

Placer County is working on parallel outcomes for adults that include economic self-sufficiency. These outcomes are intended to be reasonable, understandable, comprehensive and allow the public, policy-makers, program administrators and staff to understand where programs are working and where problems remain.

Santa Cruz County Children's System of Care. Santa Cruz County has developed a continuum of services for children who could benefit from integrated services. Unlike Placer County, Santa Cruz has not attempted to build a multi-agency collaborative. The Santa Cruz Children's System of Care is a highly coordinated model between mental health, probation, social services and education. The county's System of Care goals are:[146]

- *Maintain children in their homes whenever possible.*
- *Place children in the least restrictive yet clinically appropriate settings when out of home.*
- *Reduce placements and costs of group home and hospital services.*
- *Reduce juvenile justice recidivism.*
- *Maintain school attendance and benefit from education.*
- *Develop and maintain a family-professional partnership.*
- *Provide culturally competent services.*
- *Use evaluation to shape policy and become accountable to families, taxpayers and legislators.*

Progress has been made, but much of the work that has been done has simply clarified for counties which state or federal agencies are responsible for the myriad regulations they must follow. Where blended funding has been realized, it has ultimately resulted in increased overhead and frustration. Funding rules require counties to report how money from different sources is spent and ensure that no money is spent on ineligible clients or unauthorized services. The added workload of reporting to multiple agencies has overwhelmed staff.

The frustration and difficulties that pilot counties have experienced with integrated services has dissuaded other counties from pursuing integration. Many maintain a "wait and see" attitude. Most question whether the benefits of integration outweigh the difficulty and risk associated with changing how programs are funded and administered.

Integration Efforts Have Had Limited Success

Evaluating the success of integration efforts is difficult. A formal analysis of the AB 1741 Youth Pilot Project found the project to be "more of a tool than a program." It does not drive the way services are provided as much as it helps counties implement other programs.[147] More significantly, very few counties are participating in AB 1741 or AB 1259.

Children's System of Care (CSOC) has been implemented in most counties, although some argue that CSOC has become a funding stream for mental health services more than a way of doing business. No county has implemented a system of care approach to serving all the needs of all children who receive care.

The barriers to realizing the goals of integration through existing efforts can be drawn from the analysis of the Youth Pilot Project, evaluations of the Children's System of Care and the experiences of individual counties. They include:

Small scale. Most integration efforts have occurred on a small scale. They target a subset of children served. Focusing on a small target population limits opportunities to leverage the efficiencies of prevention and pursue economies of scale. Small, targeted projects also are less likely to drive the delivery of other services.

Counties assume majority of risk. Some state efforts to promote integration, such as Children's System of Care, have provided additional funding, while others have not. One barrier to expanding integration efforts is that local agencies assume the majority of risk for outcomes. Integrating services means changing the way counties provide care.

Change always involves new risks that can diminish enthusiasm for new approaches.

Staff turnover. As discussed in Finding 4, California is facing a shortage of qualified mental health staff. The change, stress and uncertainty of implementing a new approach to caring for children has caused some counties to experience additional staff shortages. One Placer County official commented that county employees were applying for work in neighboring counties because they were more comfortable with the status quo approach to providing services and did not want to deal with the headaches of working in a new service system.

Integration has not included federal funds. Medi-Cal is a primary source of funding and drives the availability of services for most families. Integration efforts have not changed the way counties can use Medi-Cal funding and thus have had limited impact on the way they operate.

No follow-up. Counties pursing program integration efforts are concerned that the State may discontinue pilot programs. This concern has discouraged some counties from undertaking significant reform.

While integration offers great promise, and offers hope that services can be driven by needs, a focus on prevention and concern for cost-effectiveness, existing efforts have been limited.

Design Programs Around the Needs of Children

California should review its efforts to integrate services. It should understand what has worked in the past, the progress of present efforts and how to maximize the potential of this service delivery approach.

Every county needs to build a system of care for all children and families. The system of care should be designed, funded, staffed and held accountable for ensuring that all children and families are safe, healthy, at home, in school or in work and out of trouble.

Ideally, a system of care should designate a single entity as responsible and accountable for providing effective and efficient multi-disciplinary services to children and their families. It should create a single point of responsibility for outcomes. A single agency does not have to mean a "super-agency." A lead agency or coordinating council can be the single responsible entity. Integration may occur through many paths. There must be a place, a person, an office where parents and children, policy-makers and the general public can get answers to their questions, access the services they need, and determine how things are working and how

Understanding the Service Delivery System

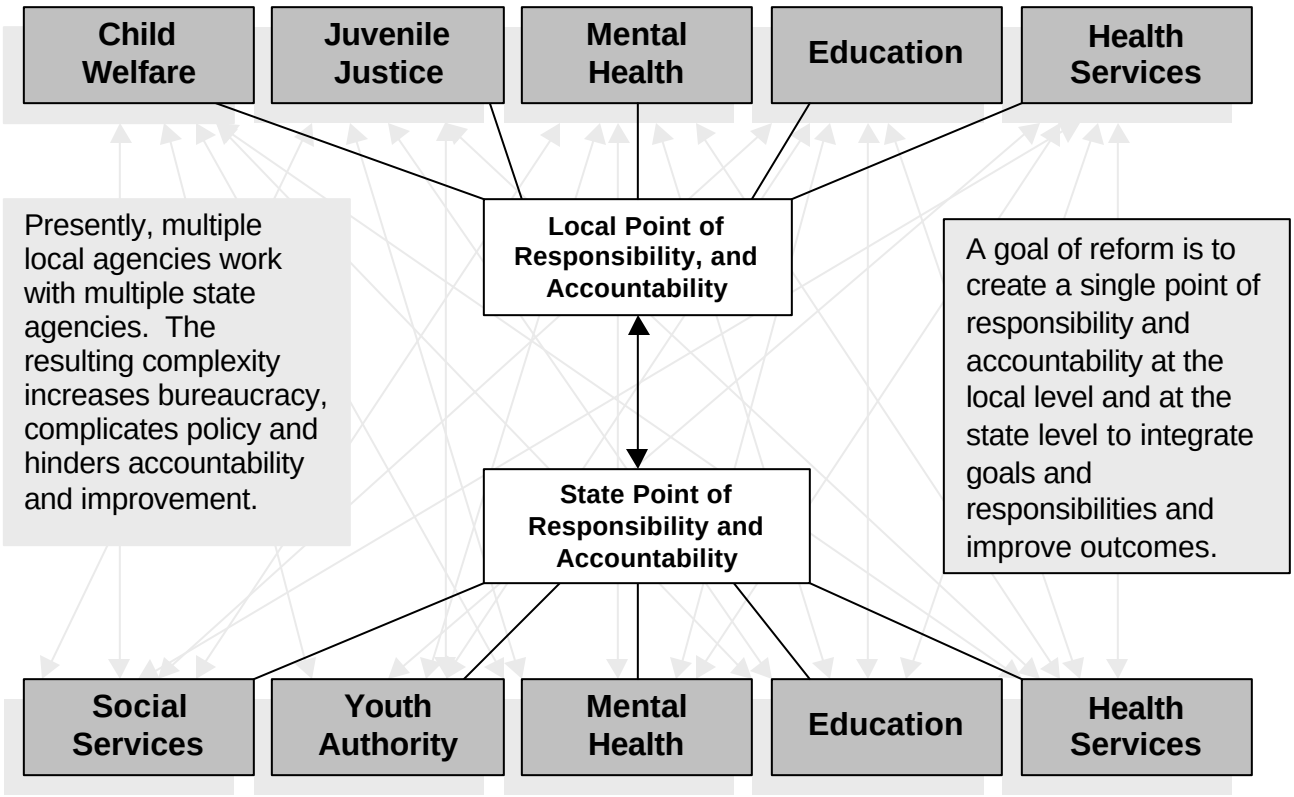
One county administrator suggested the best way for state and county policy-makers to understand the service delivery system – with all its strengths and limitations – would be to invite policy-makers to "experience" the system as clients do.

Invite policy-makers to spend a day in the shoes of a family with a troubled child. Let policy-makers and county leaders experience the frustrations of trying to make disparate programs work as a system.

they could be working better. Each child – each family – should have a single responsible contact who can guide them through the system and see that their needs are met.

Local agencies also need a single point among the multiple state agencies, departments and programs where they can turn to remove obstacles, receive technical assistance, and hold the state accountable for its support of integration efforts. The State must integrate its own funding, regulation and oversight. It also must establish goals that recognize the inter-related nature of state programs: All children in California and their families should be safe, healthy, at home, in school/in work and out of trouble. Those goals should guide funding and policy decisions as well as the design of state departments and programs.

Local Child and Family Services



State Child and Family Departments

Recommendation 5: The Governor and the Legislature should ensure that no child or family suffers needlessly because state and local programs fail to work toward common objectives. The Legislation should:

- ***Establish policy goals.*** California must ensure that state and local policies and programs support the overall well-being of children and families. All public policies should be guided by the following goals: All children and families should be safe, healthy, at home, in school or in work, and out of trouble.

- ***Establish an innovation project.*** A five-year innovation project should allow local agencies to design a service delivery system to achieve the above policy goals. Innovation projects should designate a single county entity that is responsible and accountable for outcomes. The State should offer a range of support for counties interested in participating, including:

  - ✓ ***Planning grants.*** Some counties are ill-equipped to move forward without significant planning. The State should offer planning grants to support local efforts.

  - ✓ ***Technical assistance.*** The State should provide technical assistance to counties struggling to address issues of confidentiality, blended funding and other concerns.

  - ✓ ***Regulatory relief.*** The State should expand and streamline existing efforts to provide regulatory relief.

  - ✓ ***Discretionary funding.*** The State should buy-out any state, federal or other funding that restricts local efforts to integrate services.

- ***Create a Secretary for Children's Services***. In previous reports, the Commission has recommended a high-ranking official responsible for integrating disparate programs serving children and youth. The Commission reiterates that recommendation with a call for a Secretary of Children's Services.

- ***Form a multi-agency coordinating committee.*** The State should offer a single point of contact to counties. The coordinating committee, headed by the Secretary, should include representatives of all state entities responsible for assisting, funding and regulating agencies that provide services to children and their families. It should evaluate the innovation project and be charged with developing strategies for overcoming barriers to statewide policy goals for counties not participating in the project.

- ***Create mechanisms for local accountability.*** Local elected officials are ultimately responsible for the performance of county programs.

The coordinating committee should identify measurable outcomes for the policy goals listed above. It should provide the guidance for local officials to develop uniform reporting mechanisms, and it should publicize outcomes.

Conclusion

California's children are its most valuable resource and its hope for the future. But many children do not have the building blocks necessary to support their healthy development and future success. They struggle in school, they contend with recurring health needs, their housing is tenuous and they may be at risk of landing in the criminal justice system. Many of these children have substantial mental health needs. The right services at the right time could help them stay safe, healthy, at home, in school, and out of trouble.

But the quality of mental health care and support that California's children receive varies by who they are and where they live. Care is commonly available for children who have gone "over the falls," but withheld from those just beginning to move downstream. We ration care to those with the greatest needs. And although this rationing is well known and decried as a problem, it is not addressed. The services available to children are not funded or administered in ways that prioritize prevention, promote efficiency or support continuous improvement. And they are not organized in ways that could improve their ability to serve children and families.

The Commission has recommended that California rethink its strategy for serving children in need of mental health services. Access to the right care at the right time should be guaranteed for all children. Policy-makers and community leaders need to support the capacity of service providers to be successful. And services should be organized around the needs of children and families. Taken together, these recommendations will improve the ability of California to enhance the prosperity of its children, its communities and the state.

The Commission has outlined an overall strategy and first steps for each challenge discussed here. Additional funding to serve children and families may be necessary, but funding alone will not bring about the results hoped for by parents and neighbors, educators and community leaders. Addressing the needs of children and families will require a new way of thinking about how they are served and the goals of those services.

Appendices & Notes

- ✓ ***Public Hearing Witnesses***
- ✓ ***Children's Mental Health Advisory Committee***
- ✓ ***Programs Serving Children & Families***
- ✓ ***Distribution of Mental Health Funding***
- ✓ ***Short-Doyle/Medi-Cal Penetration Rate for EPSDT Services***
- ✓ ***Glossary of Terms***
- ✓ ***Children's Mental Health Information Sources and Organizations***
- ✓ ***Notes***

Appendix A

Little Hoover Commission Public Hearing Witnesses

Witnesses Appearing at Little Hoover Commission
Children's Mental Health Hearing on October 26, 2000

Ross Andelman, M.D.
Contra Costa County Children's Services

Donna Dahl,
Children's Services Program Manager
Riverside Department of Mental Health

Sharon Hodges
Florida Mental Health Institute

John Landsverk, Director
Child and Adolescent Services
Research Center
Children's Hospital, San Diego

Gary Macbeth
Macbeth and McGaughey

Sandra Naylor Goodwin, Executive Director
California Institute for Mental Health

Nancy Presson, Acting Director
Community Mental Health Services

Abram Rosenblatt
Child Services Research Group
University of California, San Francisco

Marvin Southard, Director
Los Angeles County Department of
Mental Health

Appendix B

Little Hoover Commission
Children's Mental Health Advisory Committee

The following people served on the Children's Mental Health Advisory Committee. Under the Little Hoover Commission's process, advisory committee members provide expertise and information but do not vote or comment on the final product. The list below reflects the titles and positions of committee members at the time of the advisory committee meetings in 2000 and 2001.

Howard Adelman, Co-Director
Center for Mental Health in Schools
Department of Psychology
University of California, Los Angeles

Jackie M. Allen
Education Programs Consultant
Student Support Services and Programs
California Department of Education

Claude Arnett, M.D.
Consulting Psychiatrist
Sacramento County Probation

Cassandra Auerbach, Director
Commission on Human Rights
Los Angeles Chapter

Melinda Bird, Managing Attorney
Protection and Advocacy, Inc.

Kathleen M. Burne, Director
El Dorado County Mental Health

Bill Carter, Deputy Director
California Institute for Mental Health – CWTAC

Sai-Ling Chan-Sew, Director
Child, Youth & Family Services
Community Mental Health
San Francisco Department of Public Health

Richard Danford, Director
Office of Patients Rights

Carmen Diaz, Parent Advocate
Los Angeles County Department of Mental Health

The Honorable Terry Friedman
Presiding Judge, Children's Court
Los Angeles County

Michael Furlong
Gevirtz Graduate School of Education
University of California, Santa Barbara

Robert Garner, Director
Alcohol and Drug Services
Santa Clara County

Suzanna Gee, Staff Attorney
Protection and Advocacy, Inc.

Sue Hance
Foster Care Branch
California Department of Social Services

Graeme Hanson, M.D.
Langley-Porter Psychiatric Institute

Karen Hart, Policy Chair
United Advocates for Children of California

John Hatakeyama, Deputy Director
Children and Youth Services
Los Angeles County Department of Mental Health

Pam Hawkins
United Advocates for Children of California
Sacramento County Division of Mental Health

Carol S. Hood, Deputy Director
System of Care
California Department of Mental Health

Tiffany Johnson, Project Coordinator
California Youth Connection

Marie Kanne Poulsen, Ph.D.
CA Infant/Preschool/Family Initiative
University of Southern California – Keck School of Medicine
University Affiliated Programs
Children's Hospital of Los Angeles

Neal Kaufman, M.D.
Primary Care Pediatrics
Cedars-Sinai Medical Center

Penny Knapp, M.D.
CA Infant/Preschool/Family Mental Health Initiative
and University of California, Davis
and California Department of Mental Health

Brent Lamb, President
Children's Community Mental Health Center

David Lehman, Chief Probation Officer
Humboldt County Department of Probation

Michelle Limón-Mólina
Protection and Advocacy, Inc.

Cynthia Lusch, Program Director
Metropolitan State Hospital

Susan Mandel, President and CEO
Pacific Clinics

Stella March, President
National Alliance for Mental Illness
Los Angeles County

Leslie Merchant, Staff Attorney
Public Counsel – Children's Rights Project

Gary Pettigrew, Interim Executive Director
California Mental Health Directors Association

Sharon Rea Zone, Research Analyst
Child Development Policy Advisory Committee

Abram Rosenblatt
Child Services Research Group
University of California, San Francisco

Kay Ryan, Executive Director
Child Development Policy Advisory Committee

Rick Saletta, Program Chief
SMART Children's System of Care/Access Services
Placer County

Carroll Schroeder, Executive Director
California Alliance of Child and Family Services

Rusty Selix
California Coalition for Mental Health

Marsha Sherman, Director
California Child Care Health Program

Marvin Southard, Director
Los Angeles County Department of Mental Health

Linda Taylor, Co-Director
Center for Mental Health in Schools
Department of Psychology
University of California, Los Angeles

Jenny Weisz, Directing Attorney
Public Counsel – Children's Rights Project

Marleen Wong, Director
Mental Health Services
Los Angeles Unified School District

Tom Wright, Chief Deputy
Institutional Services
Orange County Probation Department

Appendix C

Programs Serving Children and Families

Children and families have access to a variety of programs that can help address their needs. These programs are funded and administered by multiple federal, state and local agencies. Community-based organizations or other contractors operate many of these programs. The following table illustrates the range of services that may be available to children and their families. The table is intended to convey the complexity of children's services and the difficulty in trying to understand what services may be available to help a particular child. Not all programs, however, are available in all communities. Information on funding is derived from multiple fiscal years; some funding may be represented more than once because some programs have multiple components for which separate funding data were not available.

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Academic Volunteer and Mentor Service Program[1]	Local education agencies	At-risk children.	Academic guidance, mentoring, role modeling and companionship to students who need motivation and encouragement.	145 projects	$10 million (2000-01)	YES	NO
Acquired Traumatic Brain Injury Project[2]	Local service centers	Persons 18 years or older with an injury to the brain that was sustained after birth.	Provides case management and other services to support clients to realize productive, independent lives.	4 projects	$500,000 state funds (2000-01)	NO	YES
Adolescent Family Life Program	Adolescent Family Life Family Programs	Eligible teens up to age 18 for females and age 20 for males.	Case management, assessment and services to promote self-sufficiency, promote health family relationships and support pregnant and parenting adolescents.	47 projects in 44 counties (approximately 14,000 teens served each year)	$8,678,000 federal funds $13,565,000 state funds (2000-01)	YES	YES
Adolescent Family Life Program (AFLP)[3]	County health departments, hospitals, schools and community-based organizations	Teen parents, their children and families.	Medical care, school support, substance abuse intervention, parenting education, domestic violence, employment support, family planning, social services, mental health services, health education, legal assistance, and housing assistance.	47 projects in 42 counties (approximately 16,000 teens are served each year)	$8,678,000 federal $13,565,000 state	YES	YES
Adolescent Sibling Pregnancy Prevention Program (ASPPP)[4]	County health departments, hospitals, schools and community-based organizations	Siblings of teen parents.	Medical care, school support services, substance abuse intervention, gang intervention, domestic/ relationship violence, social programs/special interest, family planning, mentoring, mental health services, health education, and social services.	44 projects (approximately 3,000 served each year)	Included in AFLP	YES	YES
Adoptions Assistance Program[5]	County adoption agencies	Children in child welfare system with emotional, physical or medical disability.	Cash assistance to adoptive parents.	All counties	State and federal funds	YES	YES

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
After School Learning and Safe Neighborhoods Partnership Program[6]	Local education agencies and community-based organizations	K-9 students.	After school enrichment programs that provide academic and literacy support.	156 projects	$87.8 million state funds (2000-01) with local match requirement	YES	NO
At-Risk Youth Demonstration Project[7]	Local workforce investment boards	At-risk youth and young adults.	Skills training services in preparation for employment.	7 projects	$1,250,000 (2000-01)	YES	NO
Black Infant Health (BIH) Program[8]	City and county health departments in conjunction with community advisory boards and/or community based organizations	Pregnant and parenting African-American women, infants, children and their families.	Provides assistance in using appropriate medical care and other family support services to ensure healthy development during first two years of an infant's life.	16 projects	2000-01 $4,065,000 federal $3,903,000 state	YES	NO
California Children and Families First Program[9]	California Children and Families Commission and County Children and Families Commissions	Children from birth to age 5.	Grant making to support array of services as determined by state and local commissions.	58 county commissions 1 state commission	$700 million (estimate) state funds (1999-00)	YES	YES
California Children Services (CCS)[10]	County health departments	Children under age 21 with physical disabilities whose families earn $40,000 or less.	Provides medical diagnosis, treatment, case management and therapy.	All counties (147,650 served in 1999-00)	$703 million state and federal funds (1997-98)	NO	NO

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
California Diabetes and Pregnancy Prevention Program[11]	California Diabetes and Pregnancy Prevention Programs	Pre-pregnant and pregnant women and infants with diabetes.	Health education, nutrition, psychosocial and medical services	10 projects	Federal funds	YES	YES
California Gang Violence Prevention Partnership[12]	Community-based organizations	At-risk youth.	Array of locally designed services to reduce gang and criminal activity and youth violence.	15 projects	$3 million (2000-01)	YES	YES
California Mentor Program[13]	Local agencies and community-based organizations	Eligibility is determined by local programs.	Mentoring program focused on self-esteem, academic achievement, interpersonal skills, family, delinquent behavior, alcohol and drug abatement, avoiding violence, pregnancy prevention and school success.	35 projects in 29 counties	$1 million	YES	YES
California Regional Centers[14]	Local Regional Centers	Children over the age of 3 and adults with a developmental disability.	Array of services according to individual needs to promote healthy development and ability to be included in communities.	21 projects	State and federal funds (2000-01)	NO	YES
California Work Opportunity and Responsibility to Kids (CalWORKs)[15]	County welfare departments	Eligibility determined by income, need and age.	Provides cash assistance to eligible individuals along with welfare-to-work services, including mental health, substance abuse, child care, transportation and other support programs.	All counties	$2,029 billion state and federal funds (2001-02)	YES	YES

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Child Abuse Treatment Program[16]	Counties, American Indian Organizations and other community-based agencies	Child victims of neglect and physical, emotional and sexual abuse and their non-offending caregivers.	Comprehensive, therapeutic treatment services.	19 projects	$2,722,263 federal funds (2000-01)	NO	YES
Child Abuse Treatment Program (CHAT)[17]	Counties that do not receive funding through the Victims of Crime Act	Child victims of neglect and physical and sexual abuse, domestic violence and other crimes.	Comprehensive, therapeutic treatment services.	25 projects	$5.3 million federal funds (2000-01)	NO	YES
Child Health and Disability Prevention (CHDP)[18]	Local health plans	Children in low-income families who are uninsured.	Children receive health screenings and immunizations.	All counties	$122 million state and federal funds (2000-01)	YES	YES
Child Sexual Abuse Treatment Program[19]	Government and non-profit agencies	Children who are victims of sexual abuse.	Comprehensive treatment services.	4 projects	$256,500 state funds (2000-01)	NO	YES
Child Sexual Exploitation Intervention Program[20]	Non-profit organizations	Child victims of sexual exploitation.	Counseling and treatment services.	4 projects	$725,500 state funds	NO	YES
Children's System of Care[21]	County mental health departments	Children with significant mental health needs.	Provides services from an array of programs, including special education, child welfare, health, and juvenile justice services.	54 counties	$44.7 million state funds (1999-00)	YES	YES

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Clothing Allowance[22]	County welfare departments	Children in foster family care who meet eligibility criteria.	Provides an allowance to purchase clothing.	All counties	State, federal and local funds	NO	NO
Community Services Block Grants[23]	Local governments and non-profit agencies	Eligibility tied to federal poverty level.	Array of services to help low-income individuals and families achieve self-sufficiency.	65 projects	$46,770,519 federal funds (2000-01)	YES	YES
Comprehensive Perinatal Services Program(CPSP)[24]	Medi-Cal providers approved for CPSP services.	Medi-Cal eligible women.	Comprehensive prenatal risk assessments, prenatal care, health education, nutrition services and psychosocial support for up to 60 days after delivery of their infants.	All counties	State and federal funds	YES	YES
Conflict Resolution and Youth Mediation[25]	Local education agencies	K-12 students.	Provides peer mediation, community outreach and curriculum integration to address issues involving conflict.	28 projects	$280,000 state funds (2000-01)	YES	NO
County Performance Incentives[26]	County welfare departments	CalWORKs eligible individuals.	Provides incentive funding to counties for moving CalWORKs recipients into employment.	All counties	Through 1999-00, $1.2 billion in state and federal funds (No allocation in 2001-02).	YES	YES
Domestic Violence Assistance American Indian Shelter Program[27]	Community-based organizations	Adult and child victims of domestic violence.	An array of services from crisis intervention programs, comprehensive shelter and long-term counseling and therapy.	2 projects	$300,000 state funds (2000-01)	NO	YES

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Domestic Violence Assistance Program[28]	Community-based organizations	Adult and child victims of domestic violence.	An array of services from crisis intervention programs, comprehensive shelter and long-term counseling and therapy.	71 projects	$13,775,755 state funds 2000-01	NO	YES
Domestic Violence Prevention[29]	Local domestic violence shelters, community organizations, county agencies and others	General population.	Provides educational and conflict resolution materials and other prevention resources, social marketing campaigns and other activities.	32 projects	Funding included under domestic violence services	YES	YES
Domestic Violence Services[30]	Local domestic violence shelters	Parents and children exposed to domestic violence.	Emergency shelter, counseling, legal assistance, transitional housing and other support services.	90 projects	$23 million state funds	YES	YES
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	County health and mental health departments	Medi-Cal eligible children ages 0-21 years.	Health, vision, dental and mental health assessments, treatment and services.	All counties	Funding included in Medi-Cal figure	YES	YES
Early Mental Health Initiative (EMHI)[31]	Local education agencies	Children in kindergarten through third grade.	Provides early mental health intervention and prevention services through school-site programs.	663 school sites in 183 local education agencies in 41 counties	$15 million state funds (2000-01)	YES	YES
Early Start[32]	Regional Centers and local education agencies	Families with children ages 0-3 who might be at risk for having a developmental disability.	Array of services according to individual needs to promote child's healthy development.	21 projects	State and federal funds (2000-01)	YES	YES

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Emergency Assistance Program	County welfare departments	Children determined to be at risk due to abuse, neglect, abandonment or exploitation.	Provides shelter care and crisis resolution.	All counties	Federal and local funds	YES	NO
Extended Independent Living Program (EILP)[33]	County welfare departments	Children ages 18-21 who were in foster care when they were age 16.	Offers training to adolescents enabling them to be independent when their foster care ends.	All counties	State funding	YES	NO
Family Preservation and Support Program/ Promoting Safe and Stable Families[34]	County welfare departments	Determined through local planning process.	Social service referrals for families with children at risk of needing out of home placements.	All counties	State and federal funds	YES	YES
Family Violence Prevention Program[35]	Government and private, non-profit agencies	Public agencies that address family violence issues.	Provides training to local agencies working to address family violence and serves as an information clearinghouse.	1 project	$194,000 state funds (2000-01)	YES	NO
Foster Parent Training and Recruitment AB 2129[36]	County welfare departments	Foster parents of foster children with special needs.	Specialized training and recruitment of foster parents.	All counties	State and federal funds	NO	NO
Foster Youth Services Program	Local education agencies	School-aged children in foster care.	Advocacy, tutoring, and instruction to enhance foster children's success in schools.	32 projects	$6,086,400	YES	NO

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Friday Night Live/Club Live/Friday Night Live Kids[37]	County alcohol and drug departments or other local agencies	High school/middle school/ elementary school students.	Supports activities that build skills and self-esteem through leadership, healthy development and problem solving activities.	54 projects	$1.1 million estimate state funds (2000-01) with additional local funds	YES	NO
Gang Risk Intervention Program[38]	Local education agencies	K-12 students.	Services, based on local needs, can include counseling, mentoring, conflict resolution training, job training and other activities. Program goal is to reduce youth involvement in gang activity.	15 projects (approximately 9,000 students and 3,000 parents served each year)	$3 million state funds	YES	NO
Gang Violence Reduction Program[39]	Community-based organizations in partnership with local law enforcement agencies	At-risk youth ages 14 to 25.	Programs provide services from five areas: Community services, victim awareness, conflict mediation, alternative activities and information sharing.	4 projects	$1,019,00 state funds (2000-01)	YES	YES
Gang Violence Suppression Program (Multi-Component)[40]	Collaborative projects involving county agencies, schools and community-based organizations	Youth involved with gang activities.	Array of locally determined services to reduce gang activities.	50 projects	$5 million state and federal funds (2000-01)	YES	NO
Gang Violence Suppression Program (Single Component)[41]	Community-based organizations	At-risk youth and families.	Array of locally determined intervention services to divert youth from gang involvement.	9 projects	$899,900 state funds (2000-01)	YES	NO

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Healthy Families Program[42]	Local health plans under contract with Managed Risk Medical Insurance Board	Children through age 19 whose families earn less than 200 percent of the federal poverty level.	Provides comprehensive health coverage, including physical, mental, vision and dental services.	All counties (Services provided to 128,572 children in 1999-00)	$656 million state and federal funds (2000-01)	YES	YES
Healthy Start Support Services for Children[43]	Local education agencies	K-12 students who meet specific eligibility criteria.	School-linked services including daycare, parenting education, transportation, medical and health, therapy, counseling, support groups, substance abuse treatment, tutoring and job training.	1,500 projects (approximately 1 million students served)	$39 million (1999-00)	YES	YES
High-Risk Youth Education and Public Safety[44]	Local education agencies or county education offices	Juvenile offenders.	Array of services, including mentoring, counseling, health education, service learning and other activities.	9 projects (approximately 6,000 students served as of June 2000)	$18 million state funds (1999-00)	YES	YES
Homeless Youth Emergency Services Program[45]	Private, non-profit agencies	Runaway and homeless youth.	Outreach services, crisis intervention, food, emergency care, counseling, case management, health screening and referrals.	2 projects	$883,000 state funds (2000-01)	YES	YES
Independent Living Program (ILP)[46]	County welfare departments	Children ages 16 and over who are in foster care.	Offers training to adolescents enabling them to be independent when their foster care ends.	All counties	State and federal funds	YES	NO

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Individuals with Disabilities Education Act (IDEA)	Multiple local agencies	Children ages 0 to 22 or 23 with disabilities.	Special education services to ensure children the opportunity to learn.	550,700 students served	$500,013,000	YES	YES
Infant Preschool Family Mental Health Initiative	County mental health departments and interagency community teams	Children from birth to age 5.	Prevention, intervention and treatment services to support the social and emotional well-being of infants and young children.	8 projects	$3.6 million state funds (2000-03)	YES	YES
Infant Supplement[47]	County welfare departments	Child living with a minor parent in out-of-home care who meets eligibility criteria.	Covers care and supervision costs for children living with a minor parent.	All counties	State, federal and local funds	NO	NO
Intergenerational Education Program[48]	Local education agencies	K-12 students.	Senior citizen volunteers provide instructional and support services to K-1 students.	10 projects	$171,000 state funds (2000-01)	YES	NO
Jobs for California Graduates[49]	Community-based organizations	Youth at-risk of dropping out of high school or dropouts.	Mentoring, tutoring, classroom support and other services to support graduation and job preparedness.	20 projects	$450,000 state funds (2000-01)	NO	YES
Juvenile Accountability Incentive Block Grant[50]	County and city agencies	Juvenile offenders.	Locally designed services intended to hold juvenile offenders accountable for their criminal activities.	58 projects	$22,598,300 federal funds (2000-01)	NO	NO

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Juvenile Crime Enforcement and Accountability Challenge Grants[51]	County coordinating councils chaired by chief probation officer	Juveniles between 11 and 17 years of age at risk for involvement with the juvenile justice system.	Provides an array of services to at-risk youth based on local needs as determined by the local coordinating council.	17 projects	$56 million state funds (1999-00)	YES	YES
Kinship Supportive Services[52]	County welfare departments	Children who are at risk of dependency or delinquency placed by juvenile court in the home of a relative.	Provides community-based family support services to relative caregivers and the children placed in their homes.	All counties	State funds	YES	YES
Local Health Department Maternal and Child Health Program[53]	Local health departments	Mothers, children and families.	Assessment and monitoring of health status indicators and the health care delivery system for maternal and child health populations.	All counties	State and federal funds	YES	NO
Medi-Cal[54]	County health and mental health departments	Individuals with health care needs who meet income criteria.	Program provides broad array of services, including physical, dental and vision needs.	All counties	$26.5 billion state and federal funds (2001-02) Includes funding in a variety of health and mental health programs.	YES	YES
Medi-Cal Mental Health Managed Care[55]	County mental health departments	Medi-Cal recipients meeting diagnostic criteria.	Array of specialty mental health services organized into a single managed care program.	All counties	$169,202,000 state and federal funds (1999-00)	YES	YES
Oakland Military Institute	California National Guard	At-risk students.	Educational program, mentoring and strict discipline to promote academic excellence, leadership, physical fitness and responsible citizenship.	1 project	State and federal funds	NO	NO

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Options for Recovery[56]	County welfare departments	HIV positive children ages newborn to 36 months with conditions resulting from alcohol substance abuse by the mother who are dependents of the court.	Covers costs of recruitment, special training and respite care of foster family providers who care for children who have medical problems related to alcohol exposure and AIDS.	All counties	State, federal and local funds	YES	YES
Oral Health[57]	Local health departments, county superintendent, or non-profit agencies	Preschool or elementary school children.	Promotes daily use of fluoride, plaque control, oral health education and other services.	29 projects in 28 counties (serves approximately 315,000 children)	$3.2 million state funds (2001-02)	YES	NO
Perinatal Outreach and Education Program[58]	Local health departments and community agencies	Pregnant women, particularly low-income women.	Outreach, assessment of tobacco-exposure risk, smoking prevention services, nursing case management, child care and other support services.	All counties	State and federal funds	YES	NO
Realignment[59]	County health, mental health, and social service agencies	Varies.	Funding is available to provide wide range of health, mental health, and social services.	All counties	$3.746 billion state funds (2000-01)	YES	$1.204 billion allocated to mental health
Regional Perinatal Programs[60]	Regional perinatal programs	Hospital staff and physicians working with pregnant women who are at risk for medical problems associated with labor and delivery and their infants.	Regional planning and coordination, information exchange, and other services.	Information not available	Federal funds	YES	NO
School Community Policing Partnership[61]	Local education agencies and law enforcement partners	At-risk children and communities.	Array of locally designed services to improve school and community outcomes, such as school crime, attendance, disciplinary actions and academic performance.	64 projects	$10 million state funds (1999-00)	YES	NO

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
School Safety and Violence Prevention[62]	Local education agencies	Students in grades 8 through 12.	Supports improved communication and training of school personnel and can fund hiring of additional staff to reduce violence on school grounds.	940 school-site projects (approximately 6 million students served)	$72.1 million	YES	YES
Special Education Pupil's Program (AB 3632)[63]	County mental health and local education agencies	School-aged children needing mental health services to meet educational goals.	Assessment, therapy, medication, case management and residential services.	All counties (9,000 served in 1997)	$59 million state funds (2000-01)	YES	YES
Specialized Care Incentive and Assistance Program (SCIAP)[64]	County welfare departments	Children in foster care with health or behavioral problems who meet eligibility requirements.	Provides funding to purchase services or to meet needs that cannot be addressed through other programs.	All counties	State funds	YES	YES
Specialized Care Rates Program[65]	County welfare departments	CalWORKs eligible children that require additional care and who are placed in a foster family home.	Compensation for additional care costs not covered by the foster family home basic rate.	All counties	State funds	NO	YES
Specialized Training for Adoptive Parents Program (STAP)[66]	County welfare departments	HIV positive children with conditions resulting from alcohol or substance abuse by the mother, who are dependents of the court or who are in the process of adoption.	Provides adoptive parents with training, intervention, education, respite care, non-medical support, and consultation regarding medical and psychological issues.	All counties	State and federal funds	YES	YES
Starbase	California National Guard	At-risk students in the 8th grade.	Applied math and science program.	1 project	Federal funds.	NO	NO

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Student Leadership[67]	Public high schools	High school students.	Provides youth development and leadership activities to support safe, healthy schools and reduce violence.	29 projects (More than 29,000 students involved in 1999-2000)	$120,000 federal funds (1999-00)	YES	YES
Sudden Infant Death Syndrome Program (SIDS)[68]	Parent volunteers and health & safety professionals	Parents of infants.	Provides training and information to the public on latest research on SIDS, also supports an educational outreach campaign on how to reduce risk.	1 project	$668,000 federal funds (2001-02)	YES	NO
Supportive and Therapeutic Options Program (STOP)[69]	County welfare departments	Children ages 0-18 who are not eligible for Medi-Cal.	Provides array of day treatment services for at-risk children and who cannot access mental health or other services.	All counties	State, federal and local funding	YES	YES
Supportive Transitional Emancipation Program[70]	County child welfare departments	Youth in foster care up to age 21.	Allows youth in foster care to participate in education and training programs to support their transition to independence.	All counties	$6.5 million	YES	NO
Targeted Truancy and Public Safety[71]	Local education agencies	Youth 15 years old or younger who have been involved with the juvenile justice system.	Supports the coordination of local services to reduce truancy and improve public safety.	10 projects	$10 million (funding for grants from 1997 – 2000)	NO	YES

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Teen Pregnancy Disincentive Program[72]	County welfare departments	Any minor parent who indicates as part of the CalWORKs application process that living with their parents would place them or their children at risk of abuse.	Provides assistance developing parenting skills, nutrition and health education and other life skills.	All counties	State, federal and local funds	YES	NO
The Healthy Families Program for Children and Youth with Serious Emotional Disturbances[73]	County mental health departments	Children enrolled in Healthy Families who meet diagnostic criteria.	Provides specialty mental health services as supplement to Healthy Families program.	Services provided to an estimated 14,000 children in 1999-00	$6,940,560 federal funds $4,627,440 state funds	YES	YES
Therapeutic Behavioral Services (TBS)[74]	County mental health departments	Medi-Cal eligible children age 0-18 who meet mental health plan criteria.	Therapy with support for challenging behaviors to create stability in residential placements.	All counties	State, federal and local funds	YES	YES
Title II – Challenge Activities Program (CAP) Component and Disproportionate Minority Confinement Component	Probation departments, education agencies, the California Youth Authority and other agencies	Juvenile offenders.	Provides an array of services to improve care and outcomes for juvenile offenders.	15 projects	$996,000 federal funds (2000-01)	YES	YES
Title II – Delinquency Prevention & Intervention Program Component	Local and community-based agencies	At-risk juveniles and juvenile offenders.	Array of locally determined services to reduce the number of children who enter the juvenile justice system.	34 projects	$8,419,000 federal funds (2000-01)	YES	YES

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Title V - Community Prevention Program Component and School Safety Program Component[75]	Local agencies, including education agencies, and community-based organizations	All children.	Locally designed services to reduce delinquency and youth violence by providing children, families, neighborhoods and institutions with the knowledge, skills and opportunities to foster health youth development.	22 projects	$4,662,000 federal funds (2000-01)	YES	YES
Victims Restitution Program	Victim Compensation and Government Claims Board	Children who are victims of/or witness crimes such as child abuse or molestation.	Reimbursement for medical/dental, mental health counseling, moving, and funeral/burial costs.	All counties	State funds	NO	YES
Work Opportunity Tax Credit (WOTC[76]**)**	Local employment development departments	CalWORKs recipients, SSI recipients, and high-risk youth ages 18-24.	Tax credit to employers who hire eligible workers.	All counties	Federal credit	YES	NO
Young Men as Fathers/ Mentoring[77]	County probation departments and county education offices	Youth ages 11 to 17 who are wards of the juvenile court.	Parent training and mentoring services.	15 projects	$1,000,000 state funds (2000-01)	YES	NO
Youth Build	Community-based organizations	At-risk youth and high school drop-outs.	Education, training and leadership development.	20 projects	$250,000 state funds (2000-01) plus additional federal funds	YES	NO
Youth Emergency Telephone Referral Network Program[78]	Community-based organization headquartered in Sacramento	All children.	Provides a hotline for children anywhere in California to link callers with local service providers.	1 project	$338,000 state funds (2000-01)	YES	YES

Program	Administrating Entity	Eligibility Criteria or Target Population	Services	Number of projects	Funding/ Source	Available for Prevention	Available for Mental Health
Youth Pilot Program (YPP)[79]	County interagency coordinating councils	Low-income, high-risk youth and their families.	Allows counties to integrate programs into a comprehensive service delivery system.	6 projects	No funding	YES	YES

Notes for Appendix C

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Appendix D

Distribution of Mental Health, AB 34 and MIOCR Funding Across California Counties, 1998–99

County	Realignment	Short–Doyle Medi–Cal	Comm. Svcs. Other Trmt.	Adult SOC	Dual Diagnosis	PATH Grants	Children's M. H. Svcs.	EPSDT
Alameda	$46,066,045	$24,413,783	-	-	-	$74,701	$370,000	$7,383,803
Alpine	182,638	-	-	-	-		50,000	-
Amador	691,391	168,085	-	-	-	2,526	50,000	53,220
Berkeley City	1,891,451	-	-	-	-	-	-	-
Butte	5,972,269	3,560,484	-	-	-	12,376	400,000	4,284,020
Calaveras	821,662	169,851	-	-	-	2,848	125,000	63,079
Colusa	655,663	203,880	-	-	-		-	46,247
Contra Costa	23,065,256	13,245,325	$34,505	-	$250,000	39,982	914,000	5,134,373
Del Norte	888,343	761,537	-	-	-	2,848	184,000	523,264
El Dorado	2,898,603	1,379,131	20,505	-	-	10,000	-	499,924
Fresno	24,925,969	8,904,553	20,505	-	-	45,278	250,000	2,670,358
Glenn	834,942	436,565	-	-	-	3,486	-	146,560
Humboldt	4,586,396	2,142,752	-	-	-	10,000	50,000	2,102,547
Imperial	4,218,098	1,871,368	-	-	-	10,000	50,000	267,321
Inyo	924,805	209,452	-	-	-	-	-	10,383
Kern	17,442,289	11,351,792	20,505	-	-	31,013	-	10,023,937
Kings	3,198,601	1,114,496	-	-	-	10,000	280,000	243,795
Lake	1,800,378	792,125	-	-	-	7,162	31,000	242,372
Lassen	877,453	234,404	-	-	-	3,003	200,000	181,881
Los Angeles	275,682,877	76,855,661	61,515	$1,883,430	-	577,271	3,482,893	32,796,664
Madera	2,837,909	1,106,566	-	-	-	10,000	248,461	914,887
Marin	9,803,149	2,492,870	40,000	-	-	10,000	350,000	571,149
Mariposa	498,831	135,984	-	-	-	1,359	154,000	94,735
Mendocino	3,058,306	1,488,033	-	-	-	10,000	315,000	816,807
Merced	6,569,904	2,805,255	-	-	250,000	11,565	-	-
Modoc	489,854	139,197	-	-	-	-	-	107,770
Mono	379,137	18,564	-	-	-	-	50,000	5,870
Monterey	8,639,554	3,909,517	-	-	-	16,882	-	1,407,450
Napa	5,015,772	1,562,361	-	-	-	9,743	350,000	987,548
Nevada	2,034,343	795,802	-	-	-	-	300,000	254,569
Orange	54,061,974	10,946,077	20,505	-	-	80,856	-	11,173,048
Placer	4,035,686	2,039,565	20,505	-	-	10,000	284,000	446,453
Plumas	660,586	260,436	-	-	-	2,498	50,000	98,399
Riverside	29,622,088	12,945,691	120,505	-	-	41,261	2,723,560	2,071,404
Sacramento	34,733,566	8,381,809	416,000	-	-	64,150	1,858,000	17,139,118
San Benito	940,944	325,158	-	-	-	-	81,000	166,672
San Bernardino	40,904,836	16,184,703	20,505	-	-	52,198	614,254	2,777,083
San Diego	67,644,465	18,512,738	20,505	-	250,000	111,291	800,000	5,977,256
San Francisco	51,620,068	28,446,868	50,000	-	-	75,882	1,000,000	4,110,119
San Joaquin	17,027,273	5,467,138	5,557	-	-	30,299	589,480	2,757,594
San Luis Obispo	4,678,388	2,594,527	-	-	-	10,000	450,000	1,556,204
San Mateo	23,684,030	-	-	-	-	24,668	746,306	2,495,114
Santa Barbara	9,028,378	7,527,170	-	-	-	15,526	725,000	5,369,457
Santa Clara	43,582,710	23,628,112	2,700,000	-	-	62,364	-	4,193,128
Santa Cruz	5,443,275	6,644,845	-	-	250,000	11,214	722,694	1,923,532
Shasta	4,989,420	2,728,629	-	-	-	10,000	300,000	952,864
Sierra	254,266	-	-	-	-	-	50,000	-
Siskiyou	1,317,806	1,148,239	-	-	-	-	250,000	1,134,185
Solano	9,887,958	4,080,841	-	-	-	15,676	1,256,078	2,223,353
Sonoma	10,281,088	4,727,055	20,505	-	-	16,405	725,000	2,985,161
Stanislaus	11,319,622	7,499,059	75,505	1,888,570	-	22,576	-	2,881,740
Sutter-Yuba	4,288,921	1,951,746	-	-	-	10,000	192,873	1,060,575
Tehama	1,894,131	1,229,829	-	-	-	6,073	-	284,356
Tri-City	2,430,593	3,349,372	-	-	-	-	-	-
Trinity	519,049	296,284	-	-	-	-	125,000	146,977
Tulare	11,280,955	4,287,221	-	-	-	22,206	50,000	2,139,046
Tuolumne	1,196,164	446,337	-	-	-	4,574	199,033	327,706
Ventura	14,090,880	8,815,278	20,505	4,000,000	-	25,271	1,333,440	552,382
Yolo	4,673,314	1,986,310	-	-	-	10,000	174,042	2,208,025
Total	**$923,044,322**	**$348,720,430**	**$3,688,132**	**$7,772,000**	**$1,000,000**	**$1,647,031**	**$23,504,114**	**$150,985,484**

Continued

Distribution of Mental Health, AB 34 and MIOCR Funding Across California Counties, 1998–99

County	Early M. H. Initiative	Mental Health Managed Care	SEPAssess Trmnt.Cas.Mgmt.	98–99 Base SAMHSA	SAMHSA Rollover	CSOC	County MOE
Alameda	$380,162	$5,509,307	$383,940	$378,270	-	-	$49,332,627
Alpine	-	7,830	12,883	-	-	-	-
Amador	-	68,265	12,883	12,563	-	-	553,827
Berkeley City	-	-	-	-	-	-	-
Butte	234,299	1,464,573	79,063	140,761	-	-	4,230,999
Calaveras	93,215	157,021	24,029	85,203	$16,899	-	740,175
Colusa	75,039	63,801	12,883	50,124	22,772	-	688,042
Contra Costa	439,078	2,130,961	477,362	1,421,004	7,700	-	19,673,983
Del Norte	-	117,977	12,883	86,257	-	-	1,142,599
El Dorado	61,897	375,279	20,919	56,427	23,028	-	3,006,814
Fresno	504,271	5,284,594	386,963	620,786	266,713	-	31,859,327
Glenn	-	159,744	12,883	88,206	-	-	1,209,373
Humboldt	164,456	469,941	46,674	211,338	145,842	$183,692	4,338,986
Imperial	335,302	795,705	62,851	222,868	-	-	2,675,116
Inyo	-	71,041	12,883	158,289	-	-	697,076
Kern	99,109	4,629,595	215,804	629,737	69,000	-	13,865,874
Kings	39,317	386,856	39,550	70,953	-	-	2,716,819
Lake	131,318	620,242	17,078	136,090	-	-	1,308,821
Lassen	-	197,190	12,883	61,546	-	-	630,342
Los Angeles	3,242,318	56,654,404	2,778,722	10,330,198	344,742	1,012,034	240,243,262
Madera	114,606	615,336	31,144	114,169	-	-	2,661,596
Marin	66,273	1,237,835	151,052	146,092	-	-	9,439,381
Mariposa	29,262	72,626	12,883	87,928	-	-	431,081
Mendocino	50,593	565,805	38,987	18,372	-	-	3,023,436
Merced	47,934	1,117,232	83,545	275,040	146,137	351,535	5,592,291
Modoc	10,246	60,200	12,883	-	-	-	368,113
Mono	-	27,395	12,883	-	-	-	411,514
Monterey	301,820	874,022	138,195	303,844	65,051	740,475	7,555,610
Napa	81,950	634,085	81,685	102,386	-	-	5,178,526
Nevada	-	222,852	27,537	33,934	2,120	-	2,043,237
Orange	588,894	10,648,633	699,001	1,043,752	-	-	47,534,021
Placer	174,517	443,719	92,966	146,111	-	444,188	3,614,065
Plumas	-	102,969	15,054	191,291	11,862	-	587,642
Riverside	694,655	7,603,312	496,344	1,691,795	-	-	29,122,454
Sacramento	606,692	9,064,486	339,791	915,196	46,230	-	23,936,806
San Benito	-	109,791	31,710	18,152	-	-	964,838
San Bernardino	1,079,275	10,333,316	721,668	1,850,813	-	-	32,276,443
San Diego	1,475,376	14,391,007	813,276	1,406,965	287,256	-	61,214,711
San Francisco	190,846	3,668,645	387,233	1,267,103	20,314	-	47,967,103
San Joaquin	477,006	3,600,358	260,686	529,768	-	-	11,019,868
San Luis Obispo	134,709	354,669	96,368	63,094	-	254,061	3,910,012
San Mateo	17,386	2,525,101	568,934	507,581	-	-	-
Santa Barbara	135,654	511,308	154,961	129,876	-	-	12,852,027
Santa Clara	765,746	4,700,639	959,599	350,860	-	-	26,088,319
Santa Cruz	166,192	2,095,504	284,054	71,261	-	-	5,706,386
Shasta	-	653,320	60,015	111,485	-	-	3,918,741
Sierra	-	-	13,841	48,318	-	-	195,267
Siskiyou	-	234,867	18,594	71,946	8,570	-	1,057,526
Solano	106,728	158,260	119,582	68,492	-	-	10,403,605
Sonoma	166,625	1,222,179	212,920	157,353	-	-	9,299,737
Stanislaus	320,273	1,963,583	208,244	335,189	-	1,001,530	11,006,239
Sutter-Yuba	-	1,463,820	66,312	192,314	27,833	-	1,115,897
Tehama	18,969	280,939	17,858	137,148	-	-	1,411,952
Tri-City	-	-	-	-	-	-	2,315,708
Trinity	-	107,661	12,883	81,884	27,102	-	537,801
Tulare	295,502	2,639,504	121,178	442,510	-	-	11,382,059
Tuolumne	42,197	213,308	14,017	24,623	-	-	879,492
Ventura	291,410	1,996,057	236,184	128,006	25,518	-	12,458,738
Yolo	-	635,366	96,797	176,135	9,824	-	3,743,254
Total	**$14,251,117**	**$166,314,035**	**$12,334,000**	**$28,001,406**	**$1,574,513**	**$3,987,515**	**$792,139,558**

Continued

Distribution of Mental Health, AB 34 and MIOCR Funding Across California Counties, 1998–99

County	County Overmatch	Medicare	Other Grants	Fees & Insurance	Other Revenue	Local Mandate SED Children	Total County Funds
Alameda	$14,071,062	$3,885,669	$8,000	$556,826	$24,303,609	$3,310,274	$180,428,078
Alpine	-	-	-	-	-	-	253,351
Amador	-	-	7,995	40,097	10,032	38,139	1,709,023
Berkeley City	-	-	-	-	-	-	1,891,451
Butte	-	53,438	431,505	149,401	2,801,540	-	23,814,728
Calaveras	-	-	-	12,842	-	-	2,311,824
Colusa	-	-	-	1,000	38,693	-	1,858,144
Contra Costa	11,877,439	-	-	1,538,506	7,820,734	1,515,167	89,585,375
Del Norte	-	11,854	110,500	38,657	29,104	-	3,909,823
El Dorado	-	-	135,796	156,435	166,222	400,660	9,211,640
Fresno	-	91,690	156,432	262,181	660,066	401,671	77,311,357
Glenn	-	-	-	8,626	-	-	2,900,385
Humboldt	-	777,619	99,178	470,803	844,994	-	16,645,218
Imperial	-	200,878	122,078	78,033	503,916	-	11,413,534
Inyo	-	4,563	-	8,792	89,854	-	2,187,138
Kern	-	-	35,912	163,762	625,525	315,176	59,519,030
Kings	34,551	45,928	-	105,698	191,336	-	8,477,900
Lake	-	-	-	95,900	31,977	-	5,214,463
Lassen	-	-	-	18,102	104,382	-	2,521,186
Los Angeles	-	2,672,600	-	3,239,488	29,674,753	12,117,090	753,649,922
Madera	-	44,020	-	42,398	72,828	-	8,813,920
Marin	-	85,009	734,085	2,439,109	1,535,347	267,642	29,368,993
Mariposa	2,500	1,788	80,570	44,999	123,754	-	1,772,300
Mendocino	-	20,324	-	71,566	35,682	-	9,512,911
Merced	-	61,014	-	135,093	83,601	-	17,530,146
Modoc	-	-	-	21,322	114,376	-	1,323,961
Mono	-	125	-	21,637	-	-	927,125
Monterey	474,304	60,586	114,418	37,850	1,042,024	516,692	26,198,294
Napa	-	-	173,639	112,453	37,344	336,249	14,663,741
Nevada	-	39,356	-	28,519	262,915	-	6,045,184
Orange	11,913,013	560,441	-	1,440,902	3,276,861	13,947,009	167,934,987
Placer	-	20,069	-	968,848	21,450	272,998	13,035,140
Plumas	-	-	-	66,519	29,611	-	2,076,867
Riverside	781,133	1,344,585	285,562	1,091,442	19,098,730	5,264,874	114,999,395
Sacramento	-	789,341	114,545	955,181	5,240,782	2,212,826	106,814,519
San Benito	-	-	-	67,177	-	-	2,705,442
San Bernardino	136,466	3,109,277	565,333	942,332	1,237,457	1,453,608	114,259,567
San Diego	-	250,153	85,000	2,192,858	454,711	306,261	176,193,829
San Francisco	15,774,694	1,987,753	833,918	545,545	22,739,694	6,335,671	187,021,456
San Joaquin	-	200,554	31,785	468,492	4,629,831	114,802	47,210,491
San Luis Obispo	852,501	543,247	-	246,563	653,461	116,757	16,514,561
San Mateo	-	-	-	-	-	3,201,367	33,770,487
Santa Barbara	300,000	511,543	1,179,635	283,745	1,719,431	300,892	40,744,603
Santa Clara	25,596,626	3,823,733	311,750	737,085	4,839,403	2,303,614	144,643,688
Santa Cruz	3,770,594	225,734	86,877	1,172,491	859,360	436,191	29,870,204
Shasta	-	1,155,969	15,865	243,927	463,569	-	15,603,804
Sierra	-	-	-	3,322	2,275	-	567,289
Siskiyou	-	5,303	-	96,305	123,378	-	5,466,719
Solano	-	-	137,291	133,188	1,211,431	431,001	30,233,484
Sonoma	-	149,642	1,081,015	180,809	2,117,810	1,342,369	34,685,673
Stanislaus	-	1,684,360	57,926	6,600,340	474,959	1,260,392	48,600,107
Sutter-Yuba	-	52,060	126,595	95,566	761,241	-	11,405,753
Tehama	-	31,640	-	92,046	309,191	-	5,714,132
Tri-City	-	65,542	-	73,554	559,778	-	8,794,547
Trinity	-	-	-	10,605	75,639	-	1,940,885
Tulare	-	92,833	129,979	138,241	280,863	61,704	33,363,801
Tuolumne	-	126,022	-	102,984	268,288	-	3,844,745
Ventura	3,988,204	25,754	125,401	774,976	1,713,245	2,014,947	52,616,196
Yolo	-	523,702	146,835	295,632	534,234	168,957	15,382,427
Total	**$89,573,087**	**$25,335,718**	**$7,525,420**	**$29,920,770**	**$144,901,291**	**$60,765,000**	**$2,836,984,943**

Appendix E

County	Short-Doyle/Medi-Cal Penetration Rate for EPSDT Services						Change
	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	1994-2000
Alameda	2.43%	2.13%	2.64%	4.57%	4.99%	4.80%	97.53%
Alpine	1.59%	1.32%	1.32%	0.72%	1.64%	0.92%	-42.14%
Amador	8.38%	5.78%	6.87%	6.87%	7.84%	8.54%	1.91%
Butte	0.80%	1.21%	3.07%	4.71%	5.92%	7.40%	825.00%
Calaveras	4.76%	3.93%	3.96%	4.52%	5.17%	4.41%	-7.35%
Colusa	2.92%	4.05%	3.90%	4.84%	6.67%	4.37%	49.66%
Contra Costa	3.65%	3.55%	4.66%	6.48%	6.91%	6.72%	84.11%
Del Norte	8.68%	8.88%	9.93%	12.00%	12.74%	13.78%	58.76%
El Dorado	3.40%	3.59%	4.97%	6.01%	7.26%	8.33%	145.00%
Fresno	1.13%	1.41%	1.60%	2.27%	2.84%	3.23%	185.84%
Glenn	1.96%	2.11%	2.59%	4.08%	4.67%	4.48%	128.57%
Humboldt	2.37%	2.85%	4.41%	5.14%	5.91%	6.56%	176.79%
Imperial	2.83%	4.51%	2.91%	3.29%	3.89%	4.57%	61.48%
Inyo	2.64%	1.98%	1.72%	1.94%	2.31%	3.23%	22.35%
Kern	2.06%	3.48%	4.79%	5.93%	6.44%	7.36%	257.28%
Kings	6.06%	5.57%	5.76%	6.29%	6.48%	6.85%	13.04%
Lake	2.22%	2.90%	2.98%	4.48%	6.91%	8.19%	268.92%
Lassen	3.11%	3.65%	4.68%	6.07%	6.37%	7.20%	131.51%
Los Angeles	1.30%	1.52%	1.77%	2.55%	3.78%	4.30%	230.77%
Madera	2.44%	2.68%	3.08%	3.83%	4.73%	5.29%	116.80%
Marin	3.05%	3.48%	4.03%	6.49%	9.78%	12.48%	309.18%
Mariposa	4.52%	5.75%	5.78%	6.80%	7.48%	8.91%	97.12%
Mendocino	1.94%	2.15%	2.23%	3.29%	4.79%	5.76%	196.91%
Merced	2.33%	2.08%	2.60%	2.72%	2.56%	2.89%	24.03%
Modoc	2.61%	3.64%	3.77%	7.87%	11.18%	14.74%	464.75%
Mono	1.53%	0.42%	1.36%	1.98%	1.70%	1.18%	-22.88%
Monterey	1.54%	1.55%	1.81%	2.40%	2.87%	3.20%	107.79%
Napa	2.70%	3.01%	2.99%	3.28%	7.32%	7.66%	183.70%
Nevada	2.66%	2.71%	4.57%	6.86%	7.44%	10.13%	280.83%
Orange	0.91%	1.14%	1.59%	3.25%	4.42%	5.14%	464.84%
Placer	1.60%	1.77%	2.28%	3.20%	4.90%	7.58%	373.75%
Plumas	5.37%	5.48%	6.29%	7.25%	8.87%	9.25%	72.25%
Riverside	3.46%	3.14%	2.71%	3.98%	4.60%	4.91%	41.91%
Sacramento	1.26%	1.86%	2.89%	4.52%	3.99%	7.65%	507.14%
San Benito	3.29%	3.45%	4.43%	4.63%	5.86%	5.82%	76.90%
San Bernardino	2.32%	1.91%	2.21%	2.82%	3.52%	3.99%	71.98%
San Diego	1.65%	1.90%	1.88%	2.39%	4.62%	5.51%	233.94%
San Francisco	4.37%	5.52%	6.26%	7.65%	9.26%	8.88%	103.20%
San Joaquin	3.77%	3.24%	3.52%	4.21%	4.41%	4.82%	27.85%
San Luis Obispo	4.31%	4.86%	5.51%	5.95%	6.69%	8.00%	85.61%
San Mateo [(a)]	3.71%	5.02%	5.80%	5.77%	No data	No data	No data
Santa Barbara	3.87%	3.30%	3.08%	4.04%	5.59%	4.74%	22.48%
Santa Clara	4.53%	3.66%	4.01%	4.29%	4.78%	4.71%	3.97%
Santa Cruz	3.47%	3.27%	4.23%	4.83%	6.56%	6.41%	84.73%
Shasta	3.55%	3.51%	3.52%	4.05%	5.31%	6.69%	88.45%
Sierra	1.81%	1.71%	3.16%	1.69%	1.79%	3.51%	93.92%
Siskiyou	5.99%	6.50%	8.20%	9.82%	12.51%	13.93%	132.55%
Solano [(b)]	4.39%	4.65%	6.09%	5.09%	**5.99%**	**4.36%**	**-0.68%**
Sonoma	3.03%	3.24%	4.55%	5.30%	6.24%	7.61%	151.16%
Stanislaus	3.46%	3.55%	3.52%	5.52%	7.69%	7.48%	116.18%
Sutter/Yuba	1.86%	2.08%	3.27%	3.69%	4.85%	5.69%	205.91%
Tehama	4.52%	3.72%	5.68%	6.70%	7.82%	8.24%	82.30%
Trinity	5.84%	6.28%	4.10%	6.34%	8.68%	9.02%	54.45%
Tulare	3.12%	3.22%	3.41%	3.53%	4.25%	4.68%	50.00%
Tuolumne	4.37%	4.48%	6.41%	9.12%	10.99%	11.57%	164.76%
Ventura	2.72%	2.79%	2.38%	2.75%	3.29%	3.54%	30.15%
Yolo	2.52%	2.40%	3.09%	4.65%	6.57%	6.75%	167.86%
Total	**2.09%**	**2.25%**	**2.60%**	**3.50%**	**4.44%**	**5.03%**	**140.67%**

(a) In FY 98-99, became a case-rate county. Data no longer available.
(b) Starting in FY 97-98, includes services provided under contract with the partnership HealthPlan of CA. Bold indicates estimates for Solano.

Appendix F

Glossary of Terms

Appropriate Services. Services designed around the specific and unique needs of individual children and families.

Assessment. A professional review of a child's needs, can include family needs related to the child's mental health.

Behavioral Therapy. A therapeutic strategy that focuses on changing unwanted behavior with rewards, reinforcements, and desensitization. Desensitization helps people address things, issues or situations that produce anxiety, fear or discomfort.

Biomedical or Medication Treatment. Using medication, often with psychotherapy, to respond to mental health needs.

Biological Factors. Factors that contribute to mental disorders that are biological in origin, such as genetics, chemical imbalances or the structure of the brain.

CalWORKs. Monthly cash assistance program for poor families with children under age 18. Additional funding available for childcare, health, and other needs related to employment.

Case Management. A service that helps people access programs appropriate to their needs. A case manager may help coordinate services from different sources, including mental health, education, health, vocational training, etc.

Children at Risk for Needing Mental Health Services. Children can be at risk for needing mental services for a variety of reasons, including physical abuse or neglect, excessive stress, witnessing or experiencing violence, alcohol and other drug use and trauma.

Continuum of Care. A continuum of care is a range of services available to a child whether their needs are minor or significant.

Co-occurring Disorders. Refers to two or more disorders occurring simultaneously. Generally refers to mental health and substance use disorders but can refer to mental health, physical health, developmental or other disorders.

Cultural Competence. Mental health services that recognize and are sensitive to diverse cultural backgrounds and beliefs.

Day Treatment. Day treatment involves services available to children during the day only. It can include educational support, counseling, vocational training and therapy.

DC: 0-3 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood in Assessment and Treatment Planning). A reference book on the mental health needs of children up to 3 years old.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition). A reference book produced by the American Psychiatric Association. The book is used by mental health professionals as a standard for making mental health diagnoses.

Early Intervention. A strategy to recognize early signs of mental health needs and responding with appropriate care to prevent the escalation of needs.

Early and Periodic Screening, Diagnosis and Treatment Program. The EPSDT program was established as a mandatory Medicaid service in 1967, and expanded by federal law in 1989. Under EPSDT, states are required to provide a broad range of screening, diagnostic, and medically necessary treatment services to Medi-Cal beneficiaries under age 21, even if the treatment is an optional service under a state's Medicaid plan. The requirements apply to mental as well as physical health care and are intended to correct or improve conditions that could be more expensive to treat later in life.

Family Therapy. An approach to therapy that involves discussions and problem-solving strategies with couples or the entire family.

Fixed Risks. Factors that can contribute to mental disorders that cannot be altered, such as genetic factors, gender or age.

Group Therapy. A way to provide therapy that involves small groups of people with similar needs.

Hospitalization. Mental health treatment in a hospital setting where the child is admitted overnight. Hospitalization provides short-term crisis stabilization and in some cases longer-term treatment.

Individuals with Disabilities Education Act (IDEA). A federal statute that entitles children with disabilities to receive Provides special education services to ensure they have appropriate opportunities to learn.

Individualized Education Program (IEP). IDEA requires that students in special education programs receive an IEP that outlines the services and supports they will receive to support their learning.

Insurance Parity. Several states and the federal government have enacted legislation to align health coverage for mental health needs with coverage available for physical health needs. These laws are intended to achieve "insurance parity," by ensuring that health plans offer mental health coverage that is comparable with their physical health coverage.

Maintenance of Effort (MOE). Under a Maintenance of Effort agreement, counties agree to maintain a specified level of funding from local sources in exchange for additional state funds. Without an MOE counties may be able to use state funds in lieu of local funds. The MOE can ensure that additional state funding increases the availability of services.

Managed Care. Managed care represents an approach to funding health care services. Generally, managed care provides a specific level of funding to serve a population of people. Managed care programs often restrict clients to seeing providers from an approved list and may limit services that are available.

Mental Disorders. Another term used for mental health needs.

Medicaid Plan. Medicaid is a jointly-funded, Federal/State health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.

Mental Health Needs. Challenges that affect thoughts, feelings, behavior and a person's body. Mental health needs can limit a person's ability to function in significant ways, even to the point of disabling a person from most of life's activities. Common mental health diagnoses include attention deficit hyperactivity disorder, anxiety disorders, eating disorders, and conduct disorder.

Mental Illness. This term is generally used in connection with adults who have serious mental health needs.

Penetration Rates. The penetration rate is used in Medi-Cal to represent the rate of service utilization. The penetration rate is determined by dividing the number of unduplicated clients by the number of average monthly eligible clients and then multiplying that number by 100. The result indicates the percent of persons eligible for Medi-Cal services who actually received one or more services.

Protective Factors. Factors that can reduce the likelihood that a person will experience a mental disorder or will reduce the severity or reoccurrence of symptoms. Stable and safe housing and social support networks are examples of potential protective factors.

Psychological Factors. Psychological attributes that can contribute to the likelihood that a person will experience a mental disorder, such as how a person responds to stress.

Rehabilitation Option/Rehabilitation Model. Federal law, under the Medicaid Rehabilitation option, allows mental health providers to bill Medi-Cal for an array of services that contribute to a client's rehabilitation. The Rehabilitation model contrasts with the Clinic Model that is more restrictive in the services that are covered.

Residential Facilities. Live-in facilities that provide treatment and support services.

Self-help. Refers to a movement within the mental health field in which clients develop and provide mental health services to other clients to promote recovery.

Serious Emotional Disturbance (SED). Disorders that severely disrupt a child's functioning or participation in the home, at school or in the community. SED includes depression, attention-deficit/hyperactivity, anxiety, conduct, and eating disorders.

Social Factors. Refers to learned behaviors and other social attributes that contribute to the likelihood that a person will develop a mental disorder.

Systems of Care. This term is often used by different people to represent different things. Generally, and as used in this report, it refers to a strategy for providing a range of services to children and families. It involves organizing multiple programs so that children and families can receive tailored services from a comprehensive continuum to meet unique and diverse needs. A systems of care approach often involves measuring the costs and outcomes of services to improve the service delivery system.

Transition Age. Many services for children stipulate that when children turn 18, 21 or 23, depending on circumstances and the program, they are no longer eligible for care. Transition age refers to those children who are transitioning out of children's services into services designed for adults.

Transitional Services. Services that help children make the shift from children's services into adult services. In most cases children are transitioning out of children's programs for which

there is no available adult equivalent services. Transitional programs can therefore include independent living services or vocational training to help the young adults live on their own.

Wrap-around Services. An approach to providing services that are individualized and designed to reduce the need for out-of-home placements. Wrap-around services are usually possible only with flexible funding that allows service providers to develop tailored treatment plans that can address an array of needs.

Appendix G

Children's Mental Health Information Sources and Organizations

The following organizations can provide useful information, data and resources on children's mental health services and policies. This is a partial list.

Educational Institutions and Research Centers

Center for Mental Health Service Research
University of California
2020 Milvia Street, # 405
Berkeley, CA 94720
http://socrates.berkeley.edu:80/~cmhsr/index.html

Center for Mental Health in Schools
Department of Psychology, UCLA
Box 951563
Los Angeles, CA 90095-1563
http://smhp.psych.ucla.edu/

State and Federal Offices

Assembly Select Committee on Mental Health
State Capitol, Room 4140
P.O. Box 942849
Sacramento, CA 94249-0001
http://www.assembly.ca.gov/acs/newcomframeset.asp?committee=83

California Board of Corrections
600 Bercut Drive
Sacramento, CA 95814
http://www.bdcorr.ca.gov/

California Department of Alcohol & Drug Programs
1700 K Street, 4th Floor
Sacramento, CA 95814
http://www.adp.cahwnet.gov/

California Department of Corrections
1515 S Street
Sacramento, CA 95814
http://www.cdc.state.ca.us/

California Department of Health Services
714 P Street
Sacramento, CA 95814
http://www.dhs.cahwnet.gov/

California Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814
http://www.dmhc.ca.gov/

California Department of Mental Health
1600 9th Street, Room 130
Sacramento, CA 95814
http://www.dmh.ca.gov/

California Department of Rehabilitation
2225 19th Street
Sacramento, CA 95818
http://www.rehab.cahwnet.gov/

California Mental Health Planning Council
1600 9th Street, Room 350
Sacramento, CA 95814
http://www.dmh.ca.gov/mhpc/default.htm

National Mental Health Services Knowledge Exchange Network (KEN)
P.O. Box 42490
Washington, DC 20015
http://www.mentalhealth.org

Senate Select Committee on Developmental Disabilities and Mental Health
State Capitol, Room 3070
Sacramento, CA 95814
http://www.sen.ca.gov/ftp/sen/committee/select/DEVELOP/_home1/PROFILE.HTM

Substance Abuse and Mental Health Services Administration
Room 12-105 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
http://www.samhsa.gov/

Non-Profit Agencies and Associations

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
http://www.aacap.org

California Alliance of Child & Family Services
2201 K Street
Sacramento, CA 95816
http://www.cacfs.org

California Association of Local Mental Health Boards & Commissions
20224 Goleta Court
Redding, CA 96002

California Association of Marriage & Family Therapists
7901 Raytheon Road
San Diego, CA 92111-1606
http://www.camft.org

California Association of School Psychologists
1400 K Street, Suite 311
Sacramento, CA 95814
http://www.casponline.org

California Association of Social Rehabilitation Agencies
Post Office Box 388
Martinez, CA 94553
http://www.casra.org

California Child, Youth and Family Coalition
1220 H Street, Suite 103
Sacramento, CA 95814
http://www.ccyfc.org

California Citizens for Health Freedom
8048 Mamie Avenue
Oroville, CA 95966
http://www.citizenshealth.org/

California Coalition for Ethical Mental Health Care
1568 6th Avenue
San Diego, CA 92101
http://www.ccemhc.org/home.html

California Council of Community Mental Health Agencies/California Coalition for Mental Health
1127 11th Street, Suite 830
Sacramento, CA 95814
http://www.cccmha.org

California Division-American Association for Marriage and Family Therapy
57 Longfellow Road
Mill Valley, CA 94941
http://www.aamft.org/

California Healthcare Association
1215 K Street
Sacramento, CA 95814
http://www.calhealth.org

California Institute for Mental Health
2030 J Street
Sacramento, CA 95814
http://www.cimh.org/

California Mental Health Directors Association
2030 J Street
Sacramento, CA 95814
http://www.cmhda.org/

California Network of Mental Health Clients
1722 J Street, Suite 324
Sacramento, CA 95814
http://www.cnmhc.org/

California Psychiatric Association
1400 K Street, Suite 302
Sacramento, CA 95814
http://www.calpsych.org/

California Psychological Association
1022 G Street
Sacramento, CA 95814
http://www.calpsychlink.org/

California Society for Clinical Social Work
720 Howe Avenue, Suite 112
Sacramento, CA 95825
http://www.cswf.org/states/calif/cascsw.html

Citizen's Commission on Human Rights
P.O. Box 1730
Thousand Oaks, CA 91358
http://www.cchr.org

Community Residential Care Association of California
P.O. Box 163270
Sacramento, CA 95816
http://hometown.aol.com/SNCNEWS/index.html

Los Angeles Coalition to End Hunger and Homelessness
548 South Spring Street, Suite 339
Los Angeles, CA 90013
http://www.lacehh.org/

LPS Task Force
203 Argonne B-104
Long Beach, CA 90803

Mental Health Association in Los Angeles County
1336 Wilshire Boulevard, 2nd Floor
Los Angeles, CA 90017-1705
http://www.mhala.org/

Mental Health Client Action Network
1024-A Soquel Avenue
Santa Cruz, CA 95062
http://www.sasquatch.com/~mhcan/index.shtml

National Alliance for the Mentally Ill California
1111 Howe Avenue, Suite 475
Sacramento, CA 95825
http://www.nami.org/about/namica/

National Association of Social Workers California Chapter
1016 23rd Street
Sacramento, CA 95816
http://www.naswca.org/

Protection & Advocacy, Inc.
100 Howe Avenue, Suite 185N
Sacramento, CA 95825
http://www.pai-ca.org/

Notes

1. Libby Anne, Abram Rosenblatt and Lonnie Snowden. 1999. "Mental Health Screening, Assessment, and Treatment Services and Additional Costs for Children in Foster Care or on Probation and their Families. A Report to the Legislature in Response to Chapter 311, Statutes of 1998. Page 21. Figure based on high estimate for foster care population in fiscal year 1995-96.
2. Sacramento County Health and Mental Health Committee, Juvenile Court Delinquency Standing Committee. Draft. February 6, 2001. Health and Mental Health Issues: A Progress Report with Key Findings and Recommendations. Page 5.
3. Health and Human Services budget. Does not include educational expenses to funding to support state and local juvenile justice and correctional programs.
4. For additional information on regional collaboratives, see the California Regional Workforce Preparation and Economic Development Program at www.regcolab.cahwnet.gov.
5. A copy of the Commission's November, 2000 report on mental health can be accessed from the Commission's Web site at www.lhc.ca.gov.
6. Little Hoover Commission. 1999. Now in Our Hands: Caring for California's Abused and Neglected Children. Sacramento, CA: Little Hoover Commission.
7. Little Hoover Commission. 1998. Beyond Bars: Correctional Reforms to Lower Prison Costs and Reduce Crime. Sacramento, CA: Little Hoover Commission.
8. Little Hoover Commission. 1994. The Juvenile Crime Challenge: Making Prevention a Priority. Sacramento, CA: Little Hoover Commission.
9. U.S. Department of Health and Human Services. 1999. Mental Health Report: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Page 39.
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